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THE FUTURE OF PSYCHOANALYSIS: CHALLENGES AND OPPORTUNITIES

BY ARNOLD M. COOPER, M.D.

The American Psychoanalytic Association has recently undergone a wrenching experience known in the shorthand of the profession as "the lawsuit." Four psychologists, on behalf of the class of psychologists, sued the American Psychoanalytic Association (the American), the Columbia University Center for Psychoanalytic Training and Research, the New York Psychoanalytic Institute, and the International Psychoanalytical Association (the IPA) under the antitrust laws, claiming that the American had, for the purpose of economic advantage, conspired to exclude psychologists from full access to psychoanalytic training and practice. I will not detail any of the steps, arguments, or merits of the lawsuit, but I do want to emphasize two major changes that occurred either consequent to or coincident with the lawsuit.

The first, coincident with the lawsuit, was the passage of the Gaskill proposal[1] in 1986 by the Executive Council of the American Psychoanalytic Association, with the overwhelming approval of its membership. This proposal stipulated that component societies of the American may accept into training any individuals who "have achieved a professional identity as human caretakers through therapeutic clinical activities of demonstrated excellence." No degree or clinical training is specified. The Gaskill proposal has opened the way for full clinical training in psychoanalysis to psychologists, social workers, nurse practitioners, and others.

The second event, directly consequent to the lawsuit, was an

This is the eighth in a series of invited papers on this topic. For previous papers, see Vol. 57, Nos. 1, 2, 3; Vol. 58, Nos. 1, 2, 3; and Vol. 59, No. 1.

[1] See Minutes of the American Psychoanalytic Association, May 1986.

agreed-upon change in the bylaws of the International Psychoanalytical Association, to permit psychoanalytic societies in America that are not part of the American to apply for direct membership in the IPA. By giving up the exclusive control of United States membership in the IPA that the American had held since a 1938 agreement, the American freed itself of any charge of obstructing access to membership in the IPA by societies that met IPA standards. At the recent meeting in Rome three existing societies in the United States, not members of the American, having been duly site-visited and assessed, were admitted to the International Psychoanalytical Association.

What have these events to do with the practice of psychoanalysis in America? I think that these little "ripples" in our organizational arrangements will profoundly alter the ways in which we psychoanalysts perceive ourselves and our profession, they will alter others' perception of us, and they will, over time, affect the way we pursue our scientific and professional lives. The changes may ultimately be beneficial for the development of psychoanalysis, increasing its influence in the culture and improving the availability of analysis for appropriate patients. However, to realize these potential benefits will require a clear view of the changes that are occurring and the new adaptations required. That is the purpose of this paper. I will discuss these issues under several headings.

1) The demedicalization of American psychoanalysis.
2) The internationalization of American psychoanalysis.
3) The changing place of psychoanalysis in American culture at large.

I also wish to issue a caveat. What follows is "futurology." I am presenting a view for discussion.

The Demedicalization of American Psychoanalysis

The Gaskill proposal represented a compromise designed to permit the full clinical training of non-medical candidates while

not specifically acknowledging that this, in fact, altered the basic character of the American Psychoanalytic Association, which, in its bylaws, explicitly states that it is formed for the purpose of training physicians. I am not discussing the wisdom or the folly of that original arrangement; that has already been debated at great length. However, the Gaskill proposal, after much discussion, avoided the task of putting to the membership the question of explicitly abandoning the medical identity of psychoanalysis, while providing the first step toward that goal. It is now clear that the necessary next step to the Gaskill proposal, that those persons trained under the Gaskill rules will have access to full membership in the American so that they will enjoy the same rights and opportunities as the medical members, requires a bylaws change, and I believe that will be enacted quickly. That change in the bylaws, providing equal membership for non-medical persons, will openly and officially eradicate any remnants of an exclusively medical identity of psychoanalysis in America.

In discussing this issue I want to be clear that in my view there has never been any question about our ability to train fine non-medical analysts. The history of psychoanalysis has to a large degree been shaped by the creative non-medical individuals who have dedicated themselves to psychoanalysis. The only questions concern the consequences of the loss of an organization in America identified as and devoted to *medical* psychoanalysis.

What will follow from this demedicalization? There can be little doubt that the demedicalization of psychoanalysis in this country has already resulted in a decline of medical applicants and will hasten that process in the future. During the past ten years (1978-1979 to 1987-1988), the most recent period for which reasonably reliable data are available from the office of the American Psychoanalytic Association, there has been roughly a 30% drop in total applications. At the same time that there has been a doubling of non-medical applications (the rise occurring since approval of the Gaskill proposal), there has

been a 50% drop in medical applications. Acceptances during this same period show a 20-25% drop in total acceptance, with a 40% drop in medical acceptances. For both groups the acceptance rate has increased, more so for the physicians. Throughout the country in 1987-1988 there were only 109 physician applications (some representing more than one application by a single applicant) and 79 were accepted out of a pool of about 1300 psychiatry residents graduating each year. In 1988-1989, 68 new medical and 30 non-medical candidates began training in the United States.

I find these statistics fairly compelling, and the trends they show will quicken in the future. Once psychoanalysis is broadly perceived as a non-medical specialty, it is unlikely that the brightest minds in graduating psychiatric residency classes will choose to cap their rigorous, time-consuming, and expensive course of doctoral and post-doctoral medical training with a subspecialization that disavows the value of their previous education. Inevitable issues of status, prestige, economic reward, and utilization of the more scarce and expensive resources of medical education will lead medical students and psychiatry residents to choose branches of psychiatry for which that prior training is essential rather than optional. It is already the case that some psychiatric residents interested in psychoanalysis, hearing about the difficulties and costs of developing an analytic career, decide that they want a personal analysis, and will get what further psychotherapy training they need one way or another, but will eschew formal psychoanalytic training.

Furthermore, studies show that a significant group of those psychiatry residents who elect analytic training were interested in analysis before beginning medical school, and becoming a psychoanalyst was one of their motivations for becoming doctors. With easier and equal access to analytic training available through other less demanding or intellectually more appealing educational pathways, it seems unlikely that this group of undergraduate potential candidates will go to medical school in the future.

At a certain point, there will be a changed perception of the ordinary pathways to becoming a psychoanalyst, and the medical applicant will be someone pursuing a "deviant" career path; in effect, leaving medicine. Psychoanalysis may always have been a non-medical activity, but in the United States, at least, it was not perceived that way. The experience in Britain, on the continent, and in Latin America is instructive. The so-called gentlemen's agreement in Britain among the three factions of the British society originally planned, I am told, that the non-medical members would be limited to one-third of the society. At the present time medical candidates are a small proportion of the student body, as is true in most countries. Demedicalization, therefore, will lead to a further overall decrease of medical applicants and a decrease in the proportion of the medical candidates of highest academic standing and aspirations, excepting the unusually talented person who feels an inner compulsion to be an analyst.

It may well be that a decline of medical talent will be more than compensated for by the encouragement of the most talented students from other fields. The case could be made that the "professionalization" of psychoanalysis has been accompanied by a "routinization" and a concern with status that are inimical to the best psychoanalytic work. Certainly, the history of psychoanalysis is replete with instances of extraordinary women and men who found their passion and their calling in psychoanalysis, often without any prior professional status. In fact, there may be an overall advantage for the profession in attracting students of more diverse, more humanistically oriented backgrounds, but it is likely to be accompanied by a decline of candidates with good scientific training and extensive clinical background.

This demedicalization will lead to an even further and more rapid erosion of the prestige that psychoanalysis has enjoyed within the medical school departments of psychiatry. Despite the fact that biological psychiatry has increasingly displaced psychoanalysis as the source of leadership within departments of

psychiatry, psychoanalysis has until now maintained a considerable place of honor within residency and medical student curricula and teaching. However, as fewer psychoanalysts are recruited from medicine, psychoanalysts within the medical school will be perceived increasingly as are psychologists and social workers—that is, as highly valued members of treatment teams that are led by physicians who are not psychoanalysts. The leadership role in psychiatry that we have taken for granted and continue to fight for will no longer be an option, and all forms of psychotherapy will increasingly be perceived as and will become a non-medical activity. This will have the significant consequence that the resources that departments of psychiatry have made available to psychoanalytic institutes, both explicitly and through trickle-down, will dry up. Fewer analysts will have major academic titles, analysts will not share in the prestige of the medical schools, and access to residents for recruitment into analytic training will diminish further. Analytic institutes will not find the medical school subtly subsidizing their candidates by permitting them to be in analytic training while residents, by providing the basic clinical training that analysts require, by providing clinical jobs while they complete training and start practice, etc.

Psychoanalysts have often been unaware of the importance of the American Psychiatric Association's sympathetic support for psychoanalysis. The APA over many years has been led primarily by medical psychoanalysts, both as medical director in the person of Dr. Melvin Sabshin and through a succession of psychoanalyst presidents. Although psychoanalysis has surely not been their prime concern, the APA has supported the American Psychoanalytic Association in a variety of ways, ranging from lobbying for at least semi-long-term dynamic psychotherapies, supporting the American's attempt to keep psychoanalytic certification out of the hands of inappropriate persons, and being certain that psychoanalysts are adequately represented in conferences on education, funding, psychotherapy research, etc. Over the last five years, the APA has

given clear signals that if the American is not perceived as a sister *medical* organization, the colleagueship reflected in the ways I just mentioned, as well as in shared back-to-back meetings and in a special role for the American on the program of the APA, may disappear. Again, this calls attention to the varieties of ways in which the medical establishment has lent its resources and prestige to further psychoanalytic aims. Psychoanalysts are used to feeling politically and scientifically isolated and unsupported, and in many respects that is true. But that is only a partial truth. We have also derived encouragement and strength from the psychiatric establishment. Will the American Psychological Association or the social work groups make up for this loss by lending their resources? Perhaps, but I believe that only the medical schools can command the huge clinical riches and the depth of faculty that have been available to us until now.

Yet another consequence of demedicalization may be the early death of the serious psychoanalytic research efforts that the American Psychoanalytic Association, both officially and among numbers of its members, is beginning to attempt to mount. There is, as we all know, an extraordinary absence of a significant cadre of full-time researchers in psychoanalysis. I refer not only to outcome research, but to whatever forms of research would be of interest for psychoanalysts to pursue, including process research. However, certain research in the modern world requires scientific training, especially the small sample research that psychoanalytic research demands. The few psychoanalysts for whom research is their major career interest are, with rare exceptions, working under the umbrella of medical schools. Departments of psychology generally do not have a strong tradition of psychoanalytic research interest. At a meeting on research last spring during the meeting of the American Psychoanalytic Association, we concluded that psychoanalysis, like every other intellectual discipline, requires university-supported, full-time researchers as part of the bedrock of the profession for our future professional well-being. We

discussed varieties of ways in which we could encourage the Board on Professional Standards to make research excellence a criterion for the assessment of institutes. We also addressed the issue of how the American might begin to find ways to encourage institutes and societies to provide the career paths and the rewards for researchers that are currently available for clinician training analysts. However, any development of full-time researchers is probably heavily dependent on medical school cooperation to provide the clinical fellowships, science support systems, and mentorship that are needed, but such cooperation is less likely as psychoanalysis loses its medical identity.

This research hurdle appears at a time when psychoanalysis is under increasing pressure to produce a research base to justify its continued existence. The spur toward research in psychoanalysis has always been minimal because the research is difficult and requires long time spans, research findings are less than usually likely to influence practice very rapidly, and research is not high on the value scale of most institutes. Will the clinical psychology training establishments pick up this task? Perhaps. To date, however, they have shown little interest, and by and large they are themselves too impoverished to provide the funding that would be required. The minimal data available from the Committee on Non-Medical Training shows that the vast majority of their admissions involve persons without significant research interest, and there is no reason to think that these individuals will develop into researchers as a result of analytic training. Demedicalization, then, is another handicap to be overcome for certain forms of analytic research, but it may also foster different research directions—research that is softer, less aimed at the scientific establishment, more in the direction of historical and literary research.

In discussing the effects of demedicalization, we should recall that psychoanalysis has a unique history in the United States. Psychoanalysis flourished here as nowhere else in the world, and it did so as a medical specialty, having largely captured both American psychiatry and the popular imagination. In some

countries, demedicalization and the training of larger numbers of analysts led, over time, to an increased number of analytic patients, a phenomenon, I assume, that is similar to the one in which the number of surgical procedures performed rises with the number of surgeons in a community. However, in these countries psychoanalysis was largely unknown to most of the patient population until a critical mass of analysts existed in the community to advocate the procedure. Demedicalization will lead to greater availability of psychoanalysis in America only if fees are lowered: in most cities psychoanalysis is already widely available, few potential patients do not know of its existence, and analysts continue to be unwilling to leave major urban centers.

Demedicalization will also be accompanied by an acceleration of the trend toward feminization of psychoanalysis, since the potential applicant pool from psychology, social work, and nursing is significantly more female than the applicant pool from psychiatric residency. Unfortunately, the almost automatic diminution of status that has accompanied feminization of all professions in all countries, as far as I know, up to the present time, will attach to psychoanalysis as it becomes increasingly female. Women do not receive equal pay or equal rewards of status and promotion for equal work, a situation we have been unable to remedy up to now.

In summary, then, the passage of the Gaskill proposal, the anticipated change of the bylaws that will provide full membership for non-medical persons, and the legitimization through IPA membership of existing non-medical institutes in the United States will very shortly confirm to potential candidates, the medical establishment, the public at large, and to ourselves that psychoanalysis is a non-medical profession. Most American psychoanalysts have taken for granted that something of their physicianly role is an intrinsic part of their personal, professional, and organizational psychoanalytic lives, and the demedicalization I have been describing will lead us toward a period of psychoanalytic identity diffusion and confusion as we struggle

to recognize and understand ourselves as members of a nonmedical profession. (Will we have patients or clients?) The cascading consequence of this altered perception of our profession will, in the short run, pose new difficulties for the successful development of psychoanalysis in the United States, although the long-range effects may be healthy.

The Internationalization of American Psychoanalysis

One immediate effect of the IPA bylaws change is the sharp change in status and prestige of institutes previously "beyond the pale," unable to participate either in the American or the IPA. These institutes now have a powerful incentive to assert their psychoanalytic presence, and judging from the IPA meeting in Rome in 1989, they will, with vigor and enthusiasm, pursue their roles as members of the international psychoanalytic community. The "legitimization" of these societies will, I hope, have the desirable effect of invigorating and enhancing their scientific life, leading their members to increased submission of their papers to American analytic journals. How will this matter? Schafer (1989) said recently, "Scholarly histories of psychoanalysis cannot afford to overlook how the play of power within organized psychoanalysis has figured importantly in the intellectual and professional history of our discipline. The exercise of power is always with us. Psychoanalysis is no exception to this general principle. The interesting and hopeful thing in this regard is that, necessarily, there occur shifts in the conditions of power and in the modes of its employment. And correlated with these shifts are shifts in the intensity of the surveillance, discipline, and punishment of those who oppose or disregard the doctrine that the powerful try to enforce. It is these shifts that enable changes to be established in what is taken to be true."

The new role of the IPA in accrediting psychoanalytic societies in America will significantly alter the existing power arrangements of which Schafer speaks, and I believe they will do so in a specific way. Those groups that find their home within

the IPA, rather than within the American, will be influenced more heavily than American psychoanalysts have been up to now by the international psychoanalytic climate, one very different from the one we know in America, and they will bring that climate to us. The atmosphere within the IPA is far more heavily Kleinian, non-medical, and diverse, both in theories and in training methods, than the one American analysts are familiar with. Independent psychoanalytic societies in America, which were aloof from the American because of theoretical differences, may find shelter under the broader theoretical umbrella of the IPA, and their ideas are likely to assume a more prominent place in the enlarged discourse of American psychoanalysis.

From the European perspective, we are extraordinarily insular. From the point of view of many American psychoanalysts, many of the international societies are based on theory that seems foreign and difficult to comprehend. For example, a recent discussion on the definition and use of the concept of projective identification (Cooper, 1989; Sandler, 1987) revealed that there are many groups of psychoanalysts who comfortably accept, as part of their core of theory and clinical work, a version of projective identification that we may have difficulty grasping, feeling aspects of it to be mythic and even mystical. Meissner (1987) implied as much in his contribution to the recently published papers from the conference on that topic. In the not-so-distant past it was relatively easy for American psychoanalysts individually, and for the American Psychoanalytic Association organizationally, to dismiss without serious discussion versions of analytic theory that did not fit our preconceptions. "Kleinian" was an epithet rather than a description and the term "object relations" was not part of our vocabulary. I think the presence of IPA societies as full-fledged members of *our* analytic community will make it necessary for American analysts to become acquainted with and consider more seriously various "foreign" versions of theory and practice that we would comfortably have dismissed in the past.

Also, societies and institutes in other parts of the world often

have looser training arrangements, based more on European models of graduate education than on American schooling models. The students, in effect, are given much greater freedom to learn as they choose, presenting themselves for some form of scrutiny when they believe they are ready. Furthermore, the issue of who becomes a training analyst is quite different in some nations. In some countries, for example, training analyst status has been synonymous with full membership in the society. The IPA is greatly concerned to raise standards among analytic communities where they are considered less than optimal, but it is likely that the IPA will never wish to achieve the uniformity and rigor that the American has been able to maintain among its own societies.

While the IPA represents a laudable intellectual and pedagogic diversity, I believe there has also been an excessive variability in minimal standards for education and for the definition of psychoanalysis. In any event, it is my guess that American psychoanalysis, able until recently to shrug at foreign training and practice, often dismissively suggesting that it is not analysis, or at least not good analysis, will now have to argue its case with new persuasiveness as it finds itself competing for candidates and patients with institutes of varied ideology that have legitimacy conferred upon them by the IPA. (Incidentally, the effort to maintain high admission standards may be strained as the number of institutes recognized by the IPA increases. To my knowledge, no faculty has ever voluntarily disbanded because the educational task was being adequately fulfilled by others; rather, they battle for students.) I hesitate to predict what the response of American analysts will be in this new international bazaar of analytic ideas. It seems to me equally likely that we will run toward fashion, as Americans have done with European clothes, or we will draw in the wagons and defend our ideas from contamination, as we have tended to do at times in the past.

At the level of clinical practice, it is an open secret in some international psychoanalytic communities and accepted fact in

others that psychoanalysis is not often conducted four times a week, and that two- and three-times-a-week "analyses" are regularly the case. The reasons may be financial, theoretical, or both. Surveys of the American (Shapiro, 1979) reveal that, despite our vigorous efforts to define analysis as a procedure requiring at least four visits a week, many members of the American label treatments of lower frequency as psychoanalysis.

As some of us have said before, the traditional attempt to define psychoanalysis by a number and a technique rather than by a process trivializes analysis. The differences between psychoanalysis and psychotherapy are quite blurred in most of the world. This has led to the desirable effort to explore the differences in terms of process and intrapsychic experience, including such considerations as differences of goals, depth of transference and countertransference attachment, forms of interpretation, depth of regression, etc. The problem is that all of these ways of defining analytic process will probably always be somewhat subjective and a bit vague. Studies seem fairly consistently to demonstrate that we are poor at predicting analyzability and that processes officially dubbed analytic by the training institute or by the analysts often do not meet the criteria of others for analytic process when carefully reviewed.

Where American psychoanalysis once held itself aloof from psychotherapy, I believe we can now predict that American psychoanalysis will increasingly concern itself with psychotherapy, because all efforts at definition will be dimensional rather than categorical, i.e., differences between psychotherapy and psychoanalysis will be quantitative, along a spectrum, rather than discontinuous. The Fall Meeting of the American Psychoanalytic Association in 1989, I assume for that reason, was dedicated to the question of the relationship between psychotherapy and psychoanalysis. Considering analysis and psychotherapy on a continuum rather than as sharply distinguished entities ought to lead to changes in curriculum, perhaps a return to what some institutes did years ago, i.e., the teaching of psychotherapy within psychoanalytic institutes, and a more serious interest in

psychotherapy research and training. It would, however, be extremely unfortunate if a broader view of the relationship of therapy to analysis led to the elimination of four- or five-times-a-week analysis for training analysis and for the candidate's cases. This form of analytic educational practice will be increasingly difficult to maintain in the future. Because it is so often the source of unique kinds of therapeutic and research opportunities, and because it is for many patients a unique therapeutic experience not duplicatable by other forms of treatment, it is worth a great struggle to maintain it. That struggle will be even greater with the proliferation of institutes competing for candidates and patients.

The diversification of analytic training, the Europeanization, if you wish, of American psychoanalysis, will have economic consequences. With the loss of academic and medical prestige, the easier availability of analytic training to persons with degrees below the doctorate level, the consequent lower total cost of analytic training, and the probable increased number of persons in training, there will be a drop in analytic fees. This drop will reflect not only economic pressures, but an altered economic self-perception of analysts—closer to mental health workers than to physicians, and separated from the higher fee structure associated with medical prestige. From the point of view of the public welfare, this ought to be a desirable development. Believing, as most analysts do, that psychoanalytic treatment is an underutilized modality, and that there is a large population that would benefit from analysis but cannot currently afford it, lowering of fees ought to bring analysis to this underserved population. (It should be noted, however, that institute treatment centers offering low-fee analysis have difficulty recruiting patients.) Available data on analytic practice (Shapiro, 1979) indicate that a significant proportion of patients are being treated with psychotherapy, who, in the analyst's opinion, would better benefit from psychoanalysis but cannot afford it. A drop in fees should make analysis available to more of this underserved group. Offsetting this advantage, however, is the like-

lihood that analysis will be further abandoned by third-party payers, as payers conclude that there is no control over the number of practitioners, meaning no possibility of controlling costs.

Psychoanalysis within American Culture

The American romance with psychoanalysis has already been through several phases, including the enormous burgeoning of intellectual and therapeutic interest in psychoanalysis during the 1940's and '50's, the rapid decline of these interests during the '60's and '70's, and now the resurgence of academic and intellectual interest at least, during the '80's. We may speculate on the reasons for these changes. Surely they include the originally excessive hopes that psychoanalysis would be a cure-all both individually and socially, and would provide an explanatory system for all intellectual puzzles. During the post-Vietnam period psychoanalysis declined in influence during the disillusionment with all sociopolitical and philosophical systems, and the tendency in America was to look to quick cures and the development of short-term rapid therapies. The proliferation of such treatments during the '60's and '70's has gradually given way to a more reasoned position for well-researched brief therapies, such as cognitive, behavioral, or interpersonal, a weeding out of the more "magical" cures, and a return of dynamic psychotherapy. We have also witnessed the transport of Lacanian ideas into intellectual discourse, and the strong academic interest in analytic propositions as they relate to literary texts, quite divorced from the clinical roots of psychoanalysis.

During the past decade, for reasons I do not know, there has been a worldwide resurgence of interest in psychodynamics and psychoanalysis in Europe, Latin America, and the Far East. Much but not all of this resurgence has been Kleinian in inclination; Kleinian analysis may have a special appeal because of its capacity to convey a more immediate sense of inner depth and

because it is freer of the "scientistic" language of the structural theory that most American medical psychoanalysts are familiar with. Again, one might predict that with demedicalization in America, Kleinian ideas will advance even more rapidly here.

If clinical psychoanalysis changes in the ways I have suggested it will, we will see a new relationship between psychoanalysis as a clinical practice and psychoanalysis as a scholarly and academic discipline. Although there is little evidence of a resurgence of interest in psychoanalytic treatment, there can be no doubt that there has been an enormous renewed interest in psychoanalysis as a body of thought. Simply tracing references to psychoanalysis in articles in the *Partisan Review*, for example, one notes that after a period of psychoanalytic absence in the 1970's, during the past decade psychoanalysis has again assumed a place of prominence in intellectual discourse, and psychoanalysis is a part of the necessary cultural background for scholars in the humanities, whether they accept or reject it.

We have already seen that an increasing proportion of our scholarly work in psychoanalysis is done by individuals from academe who are not themselves clinically trained or for whom clinical training is secondary to their scholarly interest. (I have in mind scholars such as Gay, Grünbaum, Grosskurth, Marcus, Sulloway, for examples.) I believe this split of scholarship and practice will widen as persons with primary interests in philosophy of science, history, biography, literary criticism, and intellectual history, for examples, find Freud, the psychoanalytic movement, the psychoanalytic model of the mind, and the nature of psychoanalytic thought enduring intellectual subjects of the twentieth and twenty-first centuries. Simultaneously, for the reasons I outlined in discussing research problems, the development of clinical techniques will be increasingly anecdotal, pragmatic, and unresearched, attracting fewer practitioners with advanced doctoral training. This shifting balance of psychoanalytic study, with our scholarly work and theoretical explorations done by individuals who are less rooted in clinical soil, will give

a different flavor to psychoanalysis—more philosophical and historical, less empiric and pathology oriented. Again, some will applaud such a shift, and others will deplore it.

Psychoanalysis has had a cultural influence in the United States unparalleled elsewhere in the world. As early as 1945, in the movie, *Spellbound*, we were given the picture of the psychoanalyst as the magician who could unfold the mind and discover the dark secrets that were hidden there. That role of the finder of secrets, the holder of arcane special privileged knowledge closely linked with the role of the physician or shaman in society, is no longer the standard role of the psychoanalyst. Currently, the psychoanalyst tends to be viewed as the comforting friend and sharer of knowledge. This view, in some respects closer to contemporary views of psychoanalysis, is also part of an erosion of the special place of psychoanalysis in American culture and its sharing of position with the counseling, pastoral, and helping professions. The recent movie, *sex, lies, and videotape*, opens with a scene of a patient in a comfortable sunny living room, sitting on a couch, talking to a largely silent therapist and informing him that she is interested in garbage, reflecting the empty, aimless, sexless life she leads. As the movie unfolds and the heroine begins to awaken sexually in response to the quiet seductiveness of a slightly perverse, impotent, voyeuristic man, the therapy session shows patient and therapist sitting on a couch together. The therapy is a shared piece of life, not an interpretive experience. The therapist mirrors the patient's life experience and seems himself to be reasonably seduceable. The earlier movie has its climax in an intrapsychic experience—the discovery of the repressed secret—while the later one has its climax in change through a new experience. All of this could be understood as attuned to our newer views of transference and countertransference, but along with the deidealization, demystification, and diffusion of therapeutic focus, there is a potential loss of the theoretical and intellectual component of psychoanalysis. Both movies reflect the popular de-

sire to bring the analyst out of his analytic position into something closer to that of friendly counselor, a tension in many analyses.

The maintenance of psychoanalysis as a discipline may depend in part on the capacity to keep that professional distance that, uniquely, is essential for this form of treatment. Both analyst and patient are under pressure to abandon this stance, and as I have elsewhere described (Cooper, 1986), one of the perils of analytic practice is the gradual erosion of the capacity to maintain this listening stance without giving way to a more participant one, more gratifying to the patient, easier for many analysts. One of the sources of the strength to maintain an analytic attitude comes from the professional, scientific, and cultural endorsement and support that reward analytic behavior with social approval. As psychotherapy and psychoanalysis increasingly blur, as I believe they will, and as analysts find that their major activity is psychotherapy, as they already do, it will be even more difficult to keep the "gold" of the idea of the analytic transference-countertransference relationship intact.

CONCLUSION

I have engaged in rampant speculation about the consequences of two well-intended, perhaps inevitable developments in American psychoanalytic organizational life. It is fashionable in the post-Reagan era to call a difficult situation an opportunity, and a hopeless one a challenge. I think we have an opportunity, not a challenge. The Gaskill proposal, the forthcoming change in the bylaws of the American, and the active presence of the IPA on our shores will fairly rapidly lead to major changes in our professional identity that will affect the way we regard ourselves in society, in the academic community, and among the helping professions. It is obvious that I think that some of these changes will be difficult to digest. Although they are not intrin-

sically harmful to the analytic enterprise, they will lead to a psychoanalysis with a different flavor than we have been used to here. The three serious problems we face as we look to the future that I have outlined are: 1) to acknowledge that there will be change; 2) to find the ways to continue to recruit bright young talent into our field; and 3) to retain the linkage of clinical experience with scholarship and research.

Recognizing change requires self-awareness and courage. If we are not medical, what are we? Our recruitment efforts ought now to be directed to the undergraduate student at the same time that we struggle to redefine our medical role. We should be trying to increase our university presence, reconsidering Freud's (1919) thoughts about the psychoanalytic university. Our new self-definition may well be closer to the liberal arts curriculum, and our focus ought to be there. New institutional arrangements will be necessary to insure our dialogue with neighboring disciplines, including medicine, and to provide clinical experience, where appropriate, for those whom we will require in our discipline. In the short run, many of us will find the changes perplexing and onerous. Some of the shifts, perhaps all of them, will turn out to be highly desirable over the longer run. In answer to those cynics who reply that in the long run we will all be dead, my reply is that psychoanalysis, as theory, therapy, research, and profession, is too sturdy for anyone to kill it. Psychoanalysis will change and develop, and if we are lucky, we will change and develop with it.

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The Gift of Laughter: On the Development of a Sense of Humor in Clinical Analysis

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THE GIFT OF LAUGHTER: ON THE DEVELOPMENT OF A SENSE OF HUMOR IN CLINICAL ANALYSIS

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Clinical analytic change often brings with it a maturing of the patient's sense of humor, leading to an internalized capacity to acknowledge pain and frustration while soothing oneself with wit. Both the nature of psychic functioning, especially the multiple meanings structured in words, and the nature of the dyadic aspects of clinical analysis contribute to this happy outcome. The structural similarities that jokes and humor bear to transference and self-analytic capacities are also considered.

"He was born with a gift of laughter and a sense that the world was mad." Sabatini's opening words describing Scaramouche (1921, p. 3) sketch the portrait of someone we turn to with delight, someone enough at peace with himself to keep alive warmth and humor in the face of frustration and pain.

Rare are those who by nature fit Sabatini's description. Yet the capacity for humor linked to wisdom about the world is available in varying degrees to all of us, and one of the special delights of clinical analysis is seeing the liberation and development of such humor in the course of a patient's analytic work. My interest here is in the realization of such a capacity for humor during the course of and through the process of analysis. I shall first try to make clear that particular developed, perhaps mature, humor which Sabatini described and to which I refer. I shall also address the phrase "the gift of," the implications of the word "gift." I will look at some clinical considerations, a sampling of the range of the development of such a

sense of humor, in practice. And finally, I will offer some thoughts on technical questions these matters imply.

THE MATURE SENSE OF HUMOR

The varieties of senses of humor are vast: lesser and greater, drier and broader, sharper and gentler, and so forth. Many sorts of laughter, such as the cruel, the sardonic, and the sadistic, are strongly colored by aggression, while other sorts are markedly charged with sexuality. Such conflictual jokes are familiar in our daily analytic work. They are not, however, what we have in mind when we speak of "the gift of laughter." Rather, we refer to a capacity for sympathetic laughter at oneself and one's place in the world. Humor of this sort does not imply pleasure in pain but reflects a regard for oneself and one's limits despite pain. With such humor there is an acceptance of oneself for what one is, an ease in being amused even if bemused. This humor exposes a mature capacity to acknowledge inner conflict and yet accept oneself with that knowledge, even when it is the knowledge of one's narcissistic limits. Such humor, often linked to an appreciation of irony, requires a self-respecting modesty based on underlying self strength and simultaneous recognition of and regard for others.

As I proceed, I shall refer to these specific aspects of what might be called sublimated or instinctually neutralized humor when I speak of the gift of laughter. Such a sense of humor implies sufficient skills of mastery for at least a partial taming of drive urgency, together with a moderation of the narcissistic demands of vanity, a respect for the authenticity of others, and a realization of the grander scale of reality beyond oneself. The quality is of acknowledgment and even acceptance of pain and loss without resignation to depressive hopelessness and hatred.

What I try to define is a *quality* of humor, a way of accepting oneself and the world with neither undue guardedness nor pretentious standing on high places. As with any human func-

tioning, the qualities cannot be known simply from considering manifest behavior. There is no brand of humor or style of wit that in its manifest expression can proclaim itself as integrated and mature. The meanings and the uses of humor within the individual's psychic world, not the outside form, determine the type of humor. Both the appearance and the deeper meanings are always individual and unique.

There likely is a line of development of the sense of humor, one that parallels both psychosexual development and the development of maturity of object relationships. From the child's earliest smile on being satisfied, through sadistic delight in manipulating others, on to the flourishing of pleasure in recognizing the limits of words yet the ability to play with words in riddles and puns, to the aggressive and sexual jokes of adolescence, and so on—the line of development is determined by constitutional drive pressures and by maturing capacity to appreciate otherness, finiteness, and the limits of reality. The adult gift of laughter, as I shall be using the phrase, refers to the relatively mature capacity to acknowledge urges and frustration, hopes and disappointments, with a humor in which bitterness is tamed but not denied.

This is a flower we all recognize on sight even though we have difficulty describing it botanically. Immature and conflictual jokes are familiar to us all. For illustration (and not as a prototypical model) I offer an example of mature humor. Robert Bak, highly regarded for his analytic skills, was known as a man dedicated to the good life. A former analysand of Bak's recalled with warmth a time in his analysis when he had been bemoaning the losses that come with disillusionment. After reviewing them in sad detail, the man had sighed, "There is no Santa Claus." Referring to the then preeminent restaurant in town, Bak answered in a sympathetic tone, "There *is* no Santa Claus . . . but there's always Lutèce!"

It is not a perfect world or an ideal world, but we deal with it as best we can and even find delight in that. Such a mature level of delight is the quality now addressed as the gift of laughter.

Freud (1905) considered *jokes* at the same early time in his development that he first considered dreams. Later, after he had moved on to appreciation of the structural implications of inner conflict, he returned to take a look at *humor* (Freud, 1927). He then addressed the ego's assertion of invulnerability in humor, even while acknowledging the trauma confronting the person. An extreme can be seen in the instance of the rogue on the gallows early Monday morning saying, "Well, this week's beginning nicely." In all uses of humor there is, as Freud (p. 162) said, a "triumph of narcissism." Clearly, such an aspect must be present whenever one says, "I can continue to look at myself and the world even in the face of my own destruction." Narcissism itself is at the same time acknowledged and ridiculed with such humor.

Such "triumph of the ego," one of "the great series of methods which the human mind has constructed in order to evade the compulsion to suffer, . . . possesses a dignity. . . . by means of which a person refuses to suffer, emphasizes the invincibility of his ego by the real world, victoriously maintains the pleasure principle—and all this, in contrast to other methods having the same purposes, *without overstepping the bounds of mental health*" (Freud, 1927, p. 163, italics added).

Freud made the point that the ability of humor to view danger as tolerable is like that of the parent who reassures the child by saying, "Look! here is the world, which seems so dangerous! It is nothing but a game for children—just worth making a jest about!" (p. 166). The internalization of such a parental view lies in the superego, consoling and protecting the ego, the legacy of benevolent parents.

Roustang (1987) noted that laughter reveals suffering as human, containing the possibility of respect. He linked humor to uncertainty and its toleration, to time, and to anguish. "Whereas, according to Kierkegaard, anguish is the kind of freedom which is imposed as an unavoidable possibility, laughter is freedom's possibility to escape from itself" (p. 711).

Chasseguet-Smirgel (1988) addressed humor by considering

its links to depression. Agreeing with Kris (1938), she felt that the greatest accomplishment of humor was that of banishing the terror of loss of love. She drew attention to Freud's carrying the roots back to the smile of the "infant at the breast when it is satisfied and satiated and lets go of the breast as it falls asleep" (Freud, 1905, p. 146, n. 2). For Chasseguet-Smirgel, "the humorist is a person trying to be his own loving mother" (1988, p. 205).

The Gift of Humor

Discussion of the early good parents reminds us that we have spoken of the *gift* of laughter. For Sabatini, the gift was a God- or nature-given gift, an endowment at birth. Could anyone doubt the existence of a variety of natural endowments, the variable capacities present at birth? It may be too simple even to think of an underlying attribute called a capacity for humor. Rather, an entire range of attributes and functions may have to coalesce to determine both the style and the range of ultimate sensibilities. These attributes include the innate strength of drives, the strength of capacities for self-taming and frustration tolerance, activity/motility styles, and the capacities for symbol formation and for a range of play with ideas. Yet, as in all other aspects of life, how a natural endowment is realized, indeed whether it even has the opportunity to become actualized, is determined by experience and fate.

Freud, too, called this a gift, "a rare and precious gift" (1927, p. 166). But Freud was emphasizing what was given through experience as the underlying capacities matured and were shaped by the actualities of an individual's life. He thus implied a question that extends to our clinical work: Can this capacity for detached amusement be given by one person to another? In asking this, I do not minimize the individual's constitution. Freud remarked that "many people are even without the capacity to enjoy humorous pleasure that is presented to them"

(1927, p. 166). Perhaps there are some whose humorlessness is beyond repair. Fortunately, clinical analysis most often leads to the appearance of some degree of humor, endowment and experience uniting for humor to flower.

We are in no position dogmatically to divide this much as constitutional and that much as experiential. Staying respectful of the limits of what is inborn, what is by inheritance given, we still can turn our attention to the more approachable, to what can be changed, that is, how experience can modify the actualization of what is given.

Experience is internalized; the ego grows around precipitates of identifications. A woman known for her wit had a young daughter just learning to speak. The sixteen-month-old child walked into the living room, bent over, put a piece of bread on her foot, looked up at the adults present, announced "Shoe," and burst out laughing. She not only knew a word and what it represented, but she was able to play with the idea, mocking the reality. Hearing the story retold, friends replied, "She comes by it naturally. She has her mother's humor."

No doubt "her mother's humor" includes an inherited constitutional capacity. But equally certain is the importance of identification. We used to speak of primary autonomous spheres of the ego, areas like the capacity for walking and talking, which develop free of conflict. But no child grows outside the human world, and children walk and talk in the manner of those who raise them. So it seems, too, with humor. A child's humor, or lack of humor, reflects the child's level of development, but it is also expressed in the idiom of the private world in which the child has grown.

Also, it is important to notice that this instance does not seem to be a function of the child's internalizing a comforting mother at a moment of pain. Rather, what has been internalized, what has been identified with, is the way the mother's mind works. The clever little girl has a way of playing with words that is a small replica of the way her mother plays with words. Adding

her own talents and freedom, she becomes a new, improved version, not merely a second-hand copy.

The role of identification is sufficiently clear that we even speak of cultural differences in humor, of national styles of humor. We talk of a dry British humor, a pained Jewish gallows humor, an irreverent French humor. (Though unknown to me, there may even be a Swiss fashion of humor.) Prejudice is present along with generalization when we speak in terms of such large groups, yet the underlying recognition of cultural patterns confirms the role of identification and shared experience in the development of brands of humor.

THE PATIENT'S HUMOR

What does this have to do with clinical analysis? Let us move from vast groups to that small and private two-person group, the clinical analytic dyad. What can an analysis do, what does it do, in terms of the gift of laughter? Might the analytic process not only be a freedom road that liberates from the slavery of inhibition and repetition but also be a technique that fosters new ways of viewing oneself, resulting in new uses of humor?

Consideration of the development of a sense of humor during analysis does not suggest that the analytic experience is a laughing matter. Engagement in relentless self-investigation with and before another person demands courage in the face of terrors and uncertainties. Shengold (1981) demonstrated the value of humor even as he emphasized the essentially painful nature of psychoanalytic work. He compared the journey to insight with Freud's tale of a poor man who stowed himself without a ticket on the fast train to Karlsbad. The man was repeatedly caught and repeatedly thrown roughly off the train each time tickets were inspected. At one of the stations near the end of his traumatic trip he met a friend who asked where he was going. "To Karlsbad," he replied, "if my constitution can stand it."

Moments of humor arise during the analytic journey. When they do, they are as multiply determined as are all other associations: their unconscious and instinctually charged aspects demand analytic attention. However, there are times when the humor appears like unexpected clearings in internal conflicts, moments not mainly defensive but rather exposing new understandings and integrations.

A markedly guarded patient, long crippled by overriding shame, reflected when once he was able to view himself more respectfully that he previously "only opened my mouth to change feet." He had been self-deprecating for very long. His new way of expressing his self-observation revealed both pain and respectful sympathy for himself in conflict. His humor, a sign of strength, was a secondary reward from his arduous labor.

There are people whose natural wit becomes inhibited by the development of an acute neurosis, such as depression. Working through the current pathology then exposes a humor already present. Here, analysis does not significantly contribute to developing a capacity for humor. Rather, it clears an interference, exposing what had always been present but temporarily hidden.

Another brief instance was evident in work with a patient who for years had been severely constricted, appearing publicly like a socially proper automaton. After much struggle to understand this quality as it appeared in the transference, she exposed an earlier unseen humor. Begrudgingly acknowledging an interest in our collaborative analytic work, she said, "All right, I'll look at reality, but only as a tourist." A remarkable capacity for subtle wit had been hidden, buried under the rubble of the psychic warfare of her development.

The ability to tolerate uncertainty and ambiguity and the ability to integrate into one's view of oneself and the world the vast mix of contradictory urges, feelings, and ideas are accepted goals of successful character analysis. They are, at the same time, the requisites for the gift of laughter. Mature humor is a reflection of analytic work successfully done.

Before considering the relative impact of the patient's analyzing position, such as the loosening of associations, and of the place of the analyst as a new person in the patient's analyzing experience, let us turn to a few clinical samples, instances intended to be illustrative of a range rather than all-inclusive.

First Illustration—An Initial Unwitting Joke

A first dream of a beginning analytic patient offers a fitting beginning illustration of the development of humor, especially apt because the humor that struck me, as the listener, was at the time of the dream unknown to the patient. He was a young musician, bright and cultured, but something of a snob. Racked by envy and disdain, he was tortured by having a place in his social and professional worlds that was distressingly junior to the position he felt properly his due.

The sense of the dream was of his receiving news of the birth of the son of a colleague. The content of the dream was the name printed on the birth announcement card: Montgomery Fink.

Grandeur and abasement, exposed side by side. Although I then remained quiet, I remember finding the name then, as now, funny. Pride and humiliation, naked and condensed.

These were the major themes of our subsequent work together. At that first moment I was able to see as humorous what had already been impinging on me in the conflicting currents of the transference. As time went on, and with it very much work, the patient himself came to see many of his own tendencies with increasing acceptance, coming to find his own humor in such circumstances.

This man's dream was at once symptomatic and witty. It was a condensation that was clearly structured like an elegant joke, one that aided the development of distance and increased understanding, an early analytic step in his development of his own mastery and, secondarily, his own sense of humor.

Second Illustration—Freeing of an Already Evident Capacity for Humor

Formal, perfectionistic, rigid obsessional patients often seem humorless, though some reveal a contemptuous sarcasm. Such patients are familiar to us.

There are at times, however, patients who expose from the start a natural humor and wit, but who consider such capacities symptoms rather than strengths. One young reporter came for analysis paralyzed by indecisiveness. His need for absolutes, his inability to integrate mixed feelings, left him frozen in the face of needed life decisions. It was with embarrassment that his humor was revealed. He felt it to be "silly," the inane humor of a little boy, a humor that showed him as cute but not an adult among adults. At first, the "silly humor" was presented as a symptom to be removed.

As oedipal conflicts were analyzed, as the patient was able to venture beyond his clinging to juniority, was able to be a man among men, he began to value his native wit and whimsy, enjoying rather than squelching them. With his father away at war he had been raised by a mother who did not seem responsive to his budding masculinity. His humor, like his sexuality, were taken as signs of smallness, weakness, qualities to be overcome. Now, feeling more respectful of himself and more secure in the world of adults, he became able to expose his humor in both professional and social circles. He was no longer ashamed of the childlike aspects of his whimsy, and his increased freedom for fantasy allowed him a humor that was often creative.

In this instance, analysis did not so much facilitate the development of an unformed humor; rather, it liberated a sense of humor already substantially developed.

Third Illustration—Growth of Previously Undeveloped Humor

The last patient's humor, though at first defensively devalued, had been present from the start. There are others whose

capacities for comfortable humor had never had the freedom to develop, those with depressed characters unable to realize their native humor. What wit that does show through is often bitter. Analysis of the depression, both working through superego pressures and allowing opportunity for mourning when necessary, may reveal an underlying potential for humor atrophied by fixation. With the following woman, the humor that broke through her depression was mainly sadistic. Analysis both helped expose her wit and aided in mastering the conflicts that kept that wit caustic.

A widow of many years consulted me at the time her youngest child was going off to college. She was militantly depressed. She was convinced she would end as a bag lady walking the streets. She ate and slept only with great difficulty, was withdrawing from her limited earlier social contacts, and led a life of isolation. She considered killing herself.

As analytic work progressed, first signs of humor had the quality of biting acerbic wit. For instance, she spoke of the House of Ruth (a local charity for abused women) as the House of Medea. As another instance, after mentioning M.A.D.D. (Mothers Against Drunk Driving), she said her own preferred charity was D.A.M., initials she said stood for Mothers Against Dyslexia.

Through analytic work, in which the direct analysis of such humor played only a minor role, her underlying character structure was explored. The youngest child, she had been conceived to cure her mother's depression. The prescription had failed. During childhood she had used a sharp tongue to protect herself against cut-throat competition with two older brothers and also to handle the excitement of over-stimulation, discharging and warding off sexual urges.

She married a controlling and withholding husband who seemed to her to repeat the ungiving qualities of her mother and the stimulating but unavailable aspects of her brothers. When he died young, she gave over her life to raising the three children she was left. She did not become involved with any new

men and, by her account, did not masturbate. Despite loneliness and sexual frustration, the years she had her children to herself were generally happy ones.

Sharp-tongued wit was the first face she showed of her humor, but as the analytic work went on, the harshness softened. Increasingly, new openings in the work were announced by jokes. When erotic feelings first made their way into the transference, she signaled the fact by telling the story of two elderly nursing home residents in adjoining wheelchairs. An old woman insisted she could tell an old man's age despite his skepticism. She challenged him to let her prove her ability. When he finally agreed to let her try, she said she first had to hold his penis. After fondling it several minutes, she announced the man was eighty-seven years old. He was astonished by her accuracy and asked how she could tell. "Easy," she answered, "you told me last week."

The humor served to bridge conflicts from displaced areas to the transference. Telling the joke had in it the wish to elicit a sexual effect in me. The patient's charged use of humor served as an introduction to and enactment of her sexual and aggressive concerns in the transference. Its analysis made what had been implicit now explicit: whether with me in the transference or with her brothers while growing up, her sexual curiosity and sexual wishes arose in *her*. They were her own.

Indeed, the grace with which the patient could use her wit with me was itself seductive. That is, the use of humor, above and beyond the contents of any specific instance, enacted the patient's subtle enticement. Analysis of the sexual nature of the transference, revealed through such humor, exposed underlying sadistic fantasies and impulses, with terrors of helplessness lying behind both.

By the time of termination, the patient not only was no longer depressed but had a broadened social life. She was increasingly known by her friends for her uncommon wit and good humor, which were now generally put to the use of opening herself in life rather than closing herself off. The pa-

tient herself, however, knew how easily her humor could fall back to sadistic biting. She came to use that knowledge as a valuable signal for introspection when such regression appeared. Old conflicts no longer interfered with her ability to take and to give pleasure.

The analysis of this woman evidenced the important links between depression and humor focused on by Chasseguet-Smirgel (1988). This woman indeed used humor as a way of becoming her own loving mother.

Fourth Illustration—A Moment of Humor in the Progressive Unfolding of the Transference

The last instance illustrated the broad movement of the patient's sense of humor over the length of an analysis. In this example I would like to turn to a more narrow moment in the midst of an analysis to demonstrate a shift of identifications in the transference related to the patient's humor.

A thirty-five-year-old writer, whose great social charm was used in the service of intense self-aggrandizing narcissism, came for analysis because of dissatisfaction with his life. After a long period of work it became apparent that he went about his seemingly lighthearted social life in a deadly earnest manner to protect himself against a sense of body fragility which he experienced as dangerously disintegrative.

Early in our work the patient happened across a brief paper I had written defending the therapist's use of humor (Poland, 1971). As he belittled and resented his father, he competitively resented my having written, and he belittled my published view as not that of a real or strong analyst. All my efforts to address his narcissism and his competitiveness were long repudiated for implying vulnerability in him or competent strength in me.

Nonetheless, gradually and with undeniable courage, the patient confronted the power of his own vanity. Careful of his appearance, he looked ten years younger than his actual age.

Now he admitted that socially he pretended to an age many years younger than he was, trying to cling to an image of idealized youth. By this time, his egotism had given way to recognition of and beginning regard for the otherness of others. Now his charming seductive humor could leave room for early evidences of humor about himself.

During one session he bemoaned the length of analysis and wondered of what use integration would prove to him if it were not obtained until he was forty-five years old. Then with a laugh he added, "Because for me, when *I* am forty-five, I'll actually be seventy!" It was apt that his humorous self-observation served to announce his readiness to give up the social façade of eternal youth. This was one of the first times he had been able to laugh at his own foibles.

The complexities of multiple determination make seeming clarities in analysis dangerous. I believe what I have described captures accurately a significant shift in the analysis. However, what serves the resolution of one conflictual level can simultaneously serve the defensive side of a deeper and, one hopes, emerging, conflictual level in the transference. There was a ring of truth in his witty introspection, but there also seemed a beginning effort to identify with me, as in a defensive and detoxifying identification with the aggressor.

The joke expressed both a new insight and a new level of defense. The capacity to look at himself and at his vanities was a major accomplishment for this man. In part, the use of humor manifested an effort to observe himself, perhaps even to identify with my analyzing functions. On the other hand, the process involved a narcissistic bribe to me in order to gain approval and relief from further free association. In the hierarchy of movement in the analytic process, what was worked out on one level served simultaneously to defend against, and thus implicitly expose, what was coming next.

My effort, then, was to respect the genuineness of the self-observation and the creativity of the humor while at the same time questioning the implied appeal for me to like him because he

would be, presumably, like me. Attention to the latter proved fruitful, leading to a world of fantasies and memories about the patient's seduction of and by his mother. But the partial mastery evidenced in his half-mocking self-reflection was neither diminished nor undone by the simultaneous effort to turn a partial insight to defensive use.

THE DEVELOPMENT OF HUMOR IN CLINICAL ANALYSIS

These vignettes have been selected to give a taste of patients' gradual transitions from humorlessness or conflicted humor to more mature senses of humor. Yet the special nature of humor, and particularly the question of "the gift of laughter," may allow us to focus specifically on some aspects of the analytic process. Humor implies in its very nature the presence of an other. Certainly, no drive can exist in actuality outside the context of an implied object; and, just as certainly, no object conceptualization has useful meaningfulness outside the context of drives. The transference presents our model: intrapsychic forces are manifest and open to examination as they become evident in a special and unique dyadic field.

Freud attended from the beginning to both dreams and jokes. Dreams took precedence of attention because they truly seem to offer a "royal road to the unconscious." They seem a very model of intrapsychic processing. Though the significance of dreaming as a form of communication within a transference relationship has been recognized, still dreams maintain their centrality as an inner dynamic whether or not others appear immediately involved.

Jokes, a developmentally early level of humor, are different. While wit and mature humor can be private, that is, with oneself as one's own private audience, the origin always implies others. There is an other made to laugh, and private humor has merely developed to the point where parts of oneself can serve

as both originator and observer. Unlike dreams, humor cannot be conceived of without uniting both inner forces and intended or imagined impact on others.

Transference is a way of relating: relating as telling, as in associations, and relating as connecting, as in attempting to elicit a feeling or a reaction. The very words used in the talking cure also carry both levels, the content and the emotional action. Humor in the clinical situation inevitably partakes of this double path, the patient's story as a tale told and as an effort to elicit and engage the analyst-other in an enactment. Although in actuality the two are facets of an experiential unity, for convenience we can consider each aspect separately.

1) The Nature of Words and the Patient's Development of Humor

The analytic situation fosters free association with resulting loosening of rigidities of word meanings and broadening of abilities to play with words. Interpretations open new levels of meaning, extending the previous range of understanding of what was thought and said. Such relaxation of constricted patterns of relating to words, to ideas and fantasies, to reality in general, leads to greater freedom of play of thoughts and feelings and greater ease in seeing both oneself and the world for what they are.

The nature of words as exploited by the nature of analytic listening offers the first push to a developing sense of humor. In listening to both words and music, analysts are particularly alert to the multiple meanings of words. This is no more than another way of saying that they listen for unconscious implications in the manifest messages of patient associations.

As Freud (1905) made clear in his study of the relation of humor to the unconscious, the experience of humor derives significantly from the economic discharge of tension. We also know that transference is manifest on many levels, not only from past to present and from others to analyst, but centrally

within the mind transference involves passage of energy from one level to another and from one symbol to another (Loewald, 1960). When we hear and interpret any condensation, any displacement, any symbol, we help free energy in the patient's mind.

Words not only make a statement, they also reveal what is hidden behind the statement. The role of metaphor is crucial in clinical communication. The literature is large, but Sharpe (1940) provided an exemplary instance in her attention to biological meanings structured in metaphor. When the analyst hears the implications of puns or of metaphorical meanings of which the patient was not aware and interprets those to the patient, the analyst draws a part of the patient a step away from the experience of the moment into a split position, one of both experiencing and noticing. In making this split (Sterba, 1934), patients move to a position of being able to notice conflicts and paradoxes, even ironies. They have the start of the ability to laugh at parts of themselves.

Certainly, our common experience is that words give this ability. We groan when we hear simple puns, but the groan, I think, is a sign of great familiarity, even, at times, of affectionate familiarity. The little girl learning to speak mentioned earlier was playing with nascent humor when she recognized that "bread" and "shoe" were different, that the words for those two were not the same as the things spoken of, and that the words could in play be interchanged. The play, the sense of pleasure, comes from the sense of mastery. Hearing and speaking of the different forces united into single names in the patient's words gives a similar pleasure of mastery, along with the singular delight that comes from making the unspeakable speakable. As a result, when working analytically, even the most staid analyst with abstinent technique and sober style contributes to patients' developing sense of humor by recognizing the implications of multiple meanings of words, the presence of puns.

The principle of multiple determination has led us to recognize and respect the presence of compromise formation behind

any manifest mental function. Freud spoke of "dream work" in his early examination of compromise formation regarding dreams. Paralleling that model, the phrase "word work" has been used to consider factors involved in the compromise formations behind choices of words (Poland, 1986). Increasing understanding of the power and limits of words, strengthened by their being heard by the analyst as tentative associations rather than immutable ultimate facts, leads to the ability to play with words. Toying with the motives behind the compromise formations involved in the processing, the choosing of words, a person is then able to play with words. "Word work" speaks of the compromise formation structured behind words used. As those forces are increasingly recognizable, a person is increasingly able to move to "word play," the economical discharge of mental energy by freer mobility and freer use of words themselves.

2) The Analyst as an Other in the Analytic Process and the Patient's Development of Humor

When patients learn over time how the analyst's comments reflect an openness of hearing and thinking, when they notice new attentiveness to multiple meanings, when they learn to listen similarly in their own private scanning of their minds, the new looseness and ease of thought can become manifest as a broadening sense of humor. Where beyond the use of words is the analyst in relation to "the gift" of laughter?

A sense of humor, like insight, cannot simply be given. It is not available on prescription. But when transference evocations do not call forth the reaction the patient expected and instead elicit an unexpected reaction such as an interpretation, then the analyst inevitably comes to function as a model for increased freedom for mental play. Thus the analytic process of transference crystallization and exploration contributes as much as does the structure of words to the capacity for humor.

There are structural similarities between the development from jokes to humor on the one hand and the development of transference in the analytic dyad on the other hand which may allow each to cast some light on the other. (For this comparison from a different slant, see also Weber [1982].)

Let us first look at jokes. Freud (1905) emphasized the object relationship implicit in jokes. Focusing on "dirty jokes," he considered their telling to be like the seduction of a woman in the presence of a third person. In this structure he saw the joke teller as a first person with the listener as third. The listener "laughs as though he were the spectator of an act of sexual aggression" (p. 97), the seduced woman serving as absent but implied second person.

The success of such a joke is measured by the listener's reaction, the laughter. Thus, not only are the skill of the telling and the gratification potential of the content essential to the joke's success, also the psychology of the listener is a crucial factor. (That, certainly, is something we all know first-hand, having told jokes with great success to some, only to find the same stories falling flat with others.)

The third person, the listener, must approach the listening from a position of some degree of propriety. He must also be able to share delight in transgressing a prohibition, otherwise he would not find pleasure in the joke. That is to say, he must have a mind that can be both shocked and also illicitly pleased by the urges expressed in the joke. As regards the possible shock, he represents a superego which threatens the joke teller's underlying anxiety, that of unsuccessfully violating taboos. And as regards the possible pleasure, he must have an ego sufficiently integrated to admit to pleasures, even illicit ones, when recognized as "only in a joke," that is, only played in words, not enacted in outer reality.

The teller tells the story and by wit captures the listener into sharing emotionally in the forbidden enactment. When the teller is successful, the listener laughs. In contrast to the joke, mature humor involves taming and internalizing both parts of

this process. There is an implicit telling oneself a joke, plus the ability to see the humor in it, whether or not the joke is shared with others.

In the analytic situation patients, the first persons, come to tell the analyst, the third person, about themselves and their relationships with the characters of their life events, the second persons. Simple telling does not an analysis make. Freud remarked that you cannot execute a man by hanging him in effigy: inner conflicts cannot be known and mastered simply by the intellectual discussion of them. If not from the first moment, then very soon the patient works to engage the analyst transferentially, that is, the patient tries to lure the analyst into participating emotionally in the patient's characteristic patterns of relating.

Both joke teller and patient start out as if to offer their listeners the manifest content of stories. And both joke teller and patient work to engage their listeners, trying to draw them actively into the experience of participating and reacting, into sharing forbidden wishes and mutually confirming the badness of authorities feared and flaunted.

If the listener is too rigid to tolerate mental play about a taboo, there can be no humorous effect. If the analyst is too rigid to tolerate trial identification, a partial tasting of the patient's processes, similarly there can be no analytic process. Also, if joke listener or analyst is too identified with the views of the tellers, humor and analytic process are lost.

In an analysis, the patient attempts to elicit the supposedly gratifying reaction, akin to the laughter of the person told a joke. It is the frustration of that wish which, in important part, permits further regression and possible insight. Yet, for the sake of understanding, analysts must leave their minds sufficiently open to get the point, to recognize and even feel some of what their patients try to elicit.

As analysts, we put our minds to work in the service of our patients. Our own various conflicts are sufficiently mastered to allow us an integrated functioning in consideration of the re-

ality of the moment, the analytic task with the patient. As the patient begins to regress, we respond with trial identifications as a way of maintaining a connection in the face of psychological separation (Greenson, 1960). However, we respond to our personal parallel regression as to a signal, recognizing the separateness of our minds from those of our patients (Olinick, *et al.*, 1973). We utilize our understandings of what has occurred within us, both similarities and differences from the patient, as a way of enriching our understanding of what we hear from the patient (Poland, 1988). Then, no matter the content of our interpretations, our words carry the implicit message, "No, I am not you nor your impulses nor your ghosts, but as a person who can know the experience of such forces, I can speak of them. Together we can find your urges and your ghosts to be speakable and identifiable. We can give them names." In the process, the patient's pull to shared enactment and the analyst's responsive pressure to merger yield to recognition of essential separateness of the two. Respectful contact across separation replaces frustrated fusion, and the patient (though not he or she alone) is changed in the process (Poland, 1975).

With the successful joke, there is the tale, the invitation to enactment, and the resulting laughter, marking the listener's having been seduced or tricked into sharing the implicit forbidden expression. With the successful analytic moment, the tale and invitation to enactment are sufficiently potent to be experienced by the analyst, but inhibition of enactment permits understanding, interpretation, and insight.

The grand sweep thus summarized takes place on repeated and gradually progressive microscopic levels. This working out and working through with constant sorting out takes place in the confused uncertainties of analytic exploration (an experience belied by the clarity of even the best *post facto* case report). It is shared exploration of the dark in many preceding hours that makes the highlights of "good hours" possible. Repeatedly, behind his or her words the patient acts with a pull to "come along with me, enact with me." Repeatedly, the analyst goes a

bit of the way, then steps aside to notice and ultimately to speak of what is going on.

To find a joke funny, the listener must be alert against being taken in and must simultaneously be willing to be taken in. To let the analytic process take hold, we, as analysts, must not only be alert against being taken in; we must also be open enough to be willing in our own privacy to go along emotionally a part of the way. Our fear of enactment cannot be so strong that we hold the line against experiencing emotional engagement. However, rather than offering the patient the comfort of our affective discharge (like the hearer's laughter following a joke), we offer understanding. The patient who starts to make a point can thus end by getting the point.

With each small step in and out—experiencing together, observing and distinguishing, the patient's mind strengthens and eases, allowing more room for looseness and play. In my first instance, that of the patient's early dream of a newborn child's being named Montgomery Fink, the patient presented a conflict in neurotic condensation. Coming to the patient's mind as an outside stranger, I first heard the name as a humorous condensation. I laughed to myself when I was with the patient. In the years of our work together, as I joined the patient in a collaborative effort of exploration, for a long time I no longer saw humor in such matters. As the analysis progressed, the patient came to a point where he could accept himself, and himself in his world. Instead of envy and contempt, he came to know humor. There should be no misunderstanding: the price for humor was paid with rage, discomfort, and pain.

As mentioned, the early capacity for jokes develops into the mature internalized sense of humor. This particular shift has a further relevance. In early jokes the teller invites the listener to share an overthrow of the superego. With mature humor, in contrast, taboos and frustrations are observed but dealt with with internal satisfaction. Now, instead of the collusion of an outsider, the speaker turns to an accepting part of him/herself

(with or without an other), and finds comfort in the face of pain. Conflictual emotions are tamed. Jokes are steps toward mature humor. They not only express conflictual urges, they also are moments of trial mastery on the road to mature humor.

This developmental shift parallels an analytic shift. Patients present themselves for analysis for the treatment of painful conflicts. However, clinical analysis takes for itself a double goal, the relief of that pain and also the development of the capacity for self-analysis. Analysis hopes for transfer of the technique so that patients can continue exploration independently.

Mastery through the multiple slight identifications, observations, distinctions, and understandings leads not only to insight but also to a gradual internalization of the analyzing process. As transference is progressively understood and mastered, the patient develops an increasing capacity for self-analysis. As outer jokes grow into inner humor, transference neurosis gives way to self-analytic skill.

3) The Analyst's Own Sense of Humor and the Patient's Development of Humor

This general question cannot be set aside without at least briefly considering the matter of the place of the analyst's own humor in the course of clinical analysis. The thought of one person's exposing his or her inner world to and with another over years of intimate engagement and finding that other person throughout those years of agony and lightness to seem totally devoid of humor is, at the least, frightening. Yet, with good clinical reasons, including those implied above, the principle of abstinence substantially constricts the appropriateness of the analyst's own direct expression of humor.

What is the role of the analyst's humor? In addition to the factors discussed, can the patient's humor grow by manifest example? Does analysis work in this area exclusively by ego

strengthening through insight and the analyzing experience, or are instances of the analyst's own expression of humor, such as that cited with Bak, also of value?

If, as seems likely, some degree of the analyst's humor is bound to show through in the course of an analysis, how much of the patient's burgeoning sense of humor is bound to reflect that of the analyst, with unanalyzed or even unanalyzable transferences included? And, as with insight, how much might be colored by identification with the process in the analyst but realized in the patient's own idiosyncratic style?

I do not believe the questions are answerable as posed. Rather, it is more realistic to consider the possible benefits and the dangers inherent when analysts *enact* their own humor. Speech is a form of action, especially potent in the analytic situation, and humorous speech is emotionally charged and especially potent.

The questions for the analyst are the same as they would be for the patient. Why now? What does the particular use of humor mean? What feelings and associations of the analyst are screened from experience by virtue of being discharged into action?

These questions apply to any intervention, and posing them ought not lead to paralysis, a destructive caricature of appropriate abstinence. Yet the questions demand fair consideration. If we use humor to discharge some aspect of our own conflicts, we do not help the development of the patient's insight, mastery, and humor. In that circumstance, we seriously inhibit progress.

Kubie (1971) gave thoughtful and strong warning against the clinician's use of humor, emphasizing especially the aggressive and even sadistic forces often, if not usually, carried by a seemingly funny intervention. Greenson (1973) remarked that he never said anything clever to a patient that he did not later regret.

Yet acceptance of the need for great caution in approaching the analyst's humor does not imply that all such humor is neces-

sarily technically wrong. Rose (1969) pointed out the model of the Fool as the one who could say to King Lear what Lear could not hear from anyone else. Regardless of how much prior analysis is done of resistances, some especially painful observations can be made digestible by slight leavening. The caution is that this be in the service of opening, not of enacting and obscuring.

In addition, the analyst's words are always those of an interpretive other, not one who knows the essential truth of the patient's meanings. Thus, a humor of modesty can mitigate authoritarian tendencies while still striving to keep faith with ruthless candor. Humor is always double edged in its use. Even seeming modesty, self-deprecating humor, runs the risk of the analyst's warding off emerging negative transferences.

Respecting Kubie's important and accurate caveats, instances of integrated and fitting humor can also be considered. To round out the instances given of the patient's humor, I offer one example, previously examined, of the analyst's expression of humor (Poland, 1971).

The patient, a forty-year-old professional man, was quite enthusiastic on starting his analytic work. He greatly valued his analysis, and he greatly valued me as his analyst. In the early months everything relating to the two of us was seen as good. His wife was for him then the embodiment of evil in the world. During that early period, the patient was pleased by whatever I said, even when I tried to interpret the transferential nature of such idealization.

After some months the patient's delight in me changed to its opposite. Where I had previously been ideal, I now was seen to be seriously flawed in all ways. He now seemed dedicated to the analysis of my defects. Whatever I said, including my efforts to observe the shift, was taken as further evidence of my own character flaws. Any comment I could make was of no avail in getting him to observe himself.

At one point, as he was recounting how seriously limited and disappointing I was, he reflected, "And to think, I used to hang on your every word." I am not now sure whether it was with a

laugh or with an exasperated sigh that I spontaneously replied, "And now *I* hang on my every word."

My intervention reflected a moment of my acceptance and acknowledgment of my exasperation, my sense of futility in making contact with the patient's observing capacity in the face of transference conflict. My use of humor stated my acceptance of the limitation of my power to impose observation on his attention, and it did so without anger or accusation aimed at him. It also credited his power to frustrate me. Issues of his power or impotence later proved central in his analytic work. What is noteworthy is that it was with my expression of humor that his passing brief reflectiveness could be extended to a broader reflection of himself in the analytic context. I am not saying that the humor was what made the shift possible for the patient. It certainly exposed my style of coming to grips with my own impotence, whether that sense of impotence arose from my identification with the patient or from my own eccentric difficulties.

My own use of humor was in no way consciously planned or contrived. It happened to be my own style of dealing with an inner conflict within the constraints of the analytic situation. Perhaps the work would have proceeded better had I been able to analyze the personal roots of my frustration so that I could have more steadily interpreted the patient directly. The humor revealed to the patient the fact that I had felt frustrated. Since that exposure was, I believe, substantially devoid of retaliation, it permitted and may even have facilitated the continuation of the work.

There is no perfect, ideal technique. Rather a tension is always present involving the multiple advantages and disadvantages of any intervention, silence, too, being an active intervention. An analysis is the patient's show, not the analyst's. While the analyst's narcissism and drives must be tamed, it seems unrealistic and even destructive to think an analysis could pass with no sense of the analyst's humanity ever revealed. Yet, it *is* the patient's show. The manifest analysis of the patient's mind takes place in a matrix of reciprocal self-inquiries (Gardner,

1983), but analysis is not a two-person group therapy. Like a very powerful spice, the analyst's humor contributes most when used in exceedingly sparing doses.

More is at stake than the technical principle of abstinence. The principle of the analyst's neutrality is of a broader range than mere technical maneuvers. While the analyst's mind must be open to that of the patient, its clinical use must always be in the service of the patient or else the price is high for both.

Furthermore, we may be experienced by the patient as expressing humor even when we neither intended to do so nor were aware of doing so. Not only the analyst, but the patient, too, listens for multiple meanings. There is more to the patient's mind than merely neurotic distortion, and the patient is able to hear what the analyst says not only with distortion but also with incisive empathic accuracy. Indeed, as an analysis proceeds, that skill is sharpened.

At times an analyst makes a comment, anything from a simple observation to an interpretation, and the patient will laugh, hearing more levels than simply that of which the analyst had been consciously aware. Very often the patient will ascribe conscious intent to the analyst, laughing and asking, "How did you mean that?" Whether noted as such or not, the patient often ascribes humor to the analyst.

The analyst's processing of what goes on takes place unconsciously as well as consciously. The words we use to address the patient, therefore, often carry messages beyond the narrow one immediately intended. The patient, in this instance, is the one to hear the unwitting messages and to move onward as a result. Analytic progress, understanding, mastery, and the growing capacity for humor are contributed to by both parties in the analytic venture.

CLOSING

As analysts we know more of pain and live more with pain than we do with humor. Humor merits recognition, respect, and

study. As we respect its development in the patient, we must also be alert to its soothing siren call away from attention to psychic horrors, loss of love and esteem, castration anxiety, death and nonbeing.

Mature humor offers an opportunity for sustenance and consolation throughout life. Insightful humor not only has its "given" aspects but is itself a gift, a gift the ego gives to itself. It offers self comfort without denial. Indeed, its mark is precisely its capacity to soothe while at the same time respecting the power of inner conflicts and outer hurts. The facilitating of the development of the patient's capacity for mature humor is one of the happiest and proudest effects of clinical analysis.

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Comments on the Clinical Analysis of Anxiety and Depressive Affect

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COMMENTS ON THE CLINICAL ANALYSIS OF ANXIETY AND DEPRESSIVE AFFECT

BY OWEN RENIK, M.D.

In listening to clinical material, the analyst frequently has to decide among several apparently valid avenues of investigation. The author examines an aspect of the way he chooses among technical alternatives. His perceptions of an analysand's motivations are influenced by two complementary affect-defense configurations: inhibition in response to anxiety and enactment of wishful fantasy in response to depressive affect. These conceptualizations act as deep structures at the base of his clinical thinking and give direction to his analytic activity. A connection is suggested between the choice to analyze one or another specific affect-defense configuration and the sequential unfolding of tolerable frustrations and gratifications for the analysand.

INTRODUCTION

One of the most familiar dilemmas of everyday clinical analytic work consists of a kind of embarrassment of riches. Listening to a patient's associations, an analyst frequently feels able to identify a number of promising lines of inquiry, all of them probably valid and deserving of attention. The question is, which would be best to pursue at the moment? Experience teaches us that while it may be possible for an analyst to communicate any number of accurate observations at a given point in analysis,

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only a minority will advance the work. Unfortunately, that an interpretation is a true statement about the analysand's mental life is only a necessary, not a sufficient, condition for the interpretation's efficacy.

Our technical rules tell us to work from the surface, to address the resistance; but the problem remains how to say where the surface lies and which is *the* resistance. The all-important matter of how to decide what to interpret when is an aspect of analytic technique that is not well spelled out theoretically. We teach it by example in supervision. In our literature, we tend to refer loosely to "analytic tact" and "timing." More explicit and systematic conceptualization of the process by which we choose among technical alternatives is needed.

In this presentation I intend to examine a fundamental aspect of the way I make clinical decisions. Like many analysts (e.g., Arlow, 1977), I try to be guided in my choice of analytic approach by the immediate state of the analysand's affects. For me, however, identification of affect is often closely interrelated with identification of defense; and I operate on the premise that certain specific defenses are associated with specific affects. My frame of reference includes two basic affect-defense configurations: inhibition in response to anxiety and enactment of wishful fantasy in response to depressive affect. I would like to explain, then illustrate by means of a case example, how these two affect-defense configurations operate as deep structures at the base of my clinical thinking, influencing the formation of my immediate perceptions and interests as I listen to patients.

I see the two configurations as complementary. Each describes an aspect of the way unpleasurable affect is managed. Both are always discernible in clinical material; but at any given moment during an analysis, one or the other will seem to me to better characterize the foremost resistances—i.e., the most immediate obstacles to self-awareness being encountered by an analysand. According to which it is, my analytic focus will change.

When I am thinking in terms of inhibition in response to anx-

iety, I tend to look at ways in which the analysand is relinquishing gratification; and when I am thinking in terms of the enactment of wishful fantasy in response to depressive affect, I tend to look at ways the analysand is achieving gratification. If the configuration that implicitly organizes my thinking corresponds to the analysand's subjective experience, investigation can go forward. If not—and if I am able to recognize the lack of synchrony—then I begin to find the other more compelling, and my analytic focus shifts accordingly. All this does not necessarily take place completely within my conscious awareness. Analytic work done in relation to one affect-defense configuration enables the other to become better exposed, so that constant oscillation between them characterizes analytic progress.

Brenner (1982) suggests that in the clinical analysis of psychic conflict we deal particularly with unpleasurable affects, and that these affects fall into two categories: anxiety and depressive affect. I find Brenner's view useful because it is congruent with phenomenology. It takes into account, in psychoanalytic terms, the basic human experience of time divided into past, present, and future. Psychic conflict is always a matter of the immediate here and now—"How do I manage the various concerns that I feel?"—but circumstances relevant to conflict can be located either in the past or in the future. Thus, many years ago, Abraham (1912) was able to observe a crucial distinction: "We fear a coming evil; we grieve over one that has occurred" (p. 137). Distress experienced in wrestling with life's problems inevitably takes the form of one or the other of the two ubiquitous mental states noted by Abraham.

In 1926 Freud introduced a systematic formulation of the psychic operations involved in fearing a coming evil by conceptualizing a category of affects—anxieties—as signals composed of sensations of unpleasure combined with ideas concerning calamity in the future. To this, Brenner has added a systematic formulation of the psychic operations involved in grieving over an evil that has occurred by conceptualizing a complementary category of affects—depressive affects—composed of sensa-

tions of unpleasure combined with ideas concerning calamity in the past. Brenner considers all anxieties and depressive affects signals, since they elicit defense—i.e., mental activity aimed at the elimination of unpleasure. He emphasizes that there are many possibilities for defense in relation to an unpleasurable affect. By conceptualizing two fundamental affect-defense configurations, inhibition in response to anxiety and enactment of wishful fantasy in response to depressive affect, I am proposing that within the wide range of possibilities for defense against unpleasurable affect there are some correlations between specific affects and specific defenses.

DEFENSES AGAINST ANXIETY AND DEPRESSIVE AFFECT

Not every form of defensive activity is associated with a particular category of unpleasurable affect. Certain features of defense can serve to eliminate the unpleasure associated with either an anxiety or a depressive affect. These are measures sometimes employed in the interests of defense that can be used to keep any unpleasurable percept, regardless of content, out of conscious awareness. They include aspects of the phenomena usually described as denial, disavowal, or distraction, and depend upon alterations in the operation of attention and related functions. Clarification and understanding of a patient's methods for wholesale avoidance of conscious awareness of disturbing mental contents, including unpleasurable affects, is always a significant part of the analysis of resistance. In some cases it comprises the central, preponderant analytic task (Renik, 1981).

However, there are also aspects of defense that are specific responses to anxiety or to depressive affect. If an unpleasurable affect is not repudiated altogether, its particular content determines the kind of defensive activity it elicits. The content of an anxiety differs importantly from the content of a depressive af-

fect. The basic human motivation to eliminate sensations of unpleasure applies identically to anxiety as to depressive affect. But each of the two affects contains a different kind of idea associated with the sensation of unpleasure, and the different kinds of ideas dictate different possibilities for the means by which unpleasure can be eliminated.

In the case of anxiety, a sensation of unpleasure is associated with an idea of a future calamity; and for this reason, inhibition, as Freud clearly spelled out in his original 1926 presentation, is the kind of defensive response called forth: if a particular action is judged to be dangerous—i.e., if it is thought that performing the action is likely to bring on a calamity—then calamity can be avoided by not performing the action; or the action can be performed less, so as to remain within safe limits; or the manner of its performance can be altered.

Inhibition here is meant in its most inclusive sense. When Freud used the term *inhibition* to describe the ego's response to anxiety, he referred not only to various reductions in function that are observable in behavior, but to the inhibition of aim (1925, p. 39) that underlies such reductions, the aim in question being that of achieving instinctual gratification. Therefore, all sorts of manifest alterations—substitutions, displacements, regressive deformations, etc.—come under the heading of inhibition. As a description of defense, inhibition denotes some degree of abdication of the pursuit of instinctual gratification for the purpose of averting the perceived danger of a calamity in the future.

On the other hand, if a calamity has already occurred, it can no longer be avoided by giving up a dangerous course of action. Therefore, it hardly makes sense to think of depressive affect, which associates a sensation of unpleasure with an idea of a calamity that has already occurred, as eliciting inhibition. Bibring (1953) realized this. From an exclusively ego-psychological perspective, he saw depressive affect as a signal of an individual's powerlessness in relation to goals. Dorpat (1977), continuing Bibring's line of thought but emphasizing the adaptive function

of affects, suggested that depressive affect elicits relinquishment of unobtainable goals with eventual formulation of new, obtainable ones.

The limitation of Dorpat's view is that it does not take account of the many maladaptive responses elicited by depressive affect, wherein goals, even if realistically unobtainable, are not relinquished. Although the idea that a calamity has occurred does signal that a goal is beyond reach, an effort to attain that goal by magical means often persists unconsciously. In my experience, a major portion of the work of clinical analysis is concerned with defensive activity of this kind aimed at eliminating the unpleasure of depressive affect.

My observation has been that specific defenses against depressive affect are enactments of fantasies in which there is repair of a calamity that is perceived as already having occurred. These fantasies, familiar to all clinical analysts, determine attitudes and behaviors occurring widely throughout life. Much psychoanalytic thinking about "depression" and "depressive illness" describes what I believe can be more usefully conceptualized as *defense elicited by depressive affect*. A case in point is the well-known idea, presented in *Mourning and Melancholia* (1917), that identification underlies depression. In the melancholic conditions Freud studied, identification defends against depressive affect. It represents an attempt to deal with an unpleasurable *fait accompli* through enactment of wishful fantasy. For example, when loss of a loved one is an established fact, an individual may respond by maintaining a fantasy that he or she is the lost loved one, or will become the lost loved one. Such a fantasy, termed an *identification* (Abend and Porder, 1986), magically reverses a calamity that has occurred.

There are other common fantasies used to defend against depressive affect besides identifications. In *Mourning and Melancholia*, Freud admittedly took a very narrow focus on a particular symptom. He used the concept of identification to explain his observation that certain melancholic individuals criticize themselves quite conspicuously and unrealistically in ways that,

while largely inappropriate when applied to themselves, fit very well to their views of others whom they love or have loved. He did not consider syndromes in which irrational self-reproach is not a conspicuous feature. There are many clinically familiar conditions in which sufferers, though helpless, hopeless, dejected, and in pain, show no tendency toward self-criticism, but instead are only too glad to find fault with the world around them. These states of so-called "narcissistic" or "empty" depression are not always illuminated by the concept of identification.

Rado helps us cast a wider net. In his article, "The Problem of Melancholia" (1928), he described what we can look upon as an entire class of defenses elicited by depressive affect. The class contains, but is not limited to, identifications. Rado traced the evolution of a group of fantasies typically enacted in reaction to the unpleasure felt when calamities occur within object relationships. What he described amounts to a developmental line for a kind of defense elicited by depressive affect. The prototype is as follows:

> You can observe in the nursery how the infant, if its craving for nourishment awakens in the absence of the mother, flies into an impotent rage, kicks and screams, and then, exhausted by this reaction to its helplessness, falls wholly . . . prey to the torments of hunger. But you know also that this cruel experience is finally followed *with unfailing certainty* by the reappearance of the mother and . . . subsequent gratification. The whole process constitutes a . . . sequence of experiences, countless times repeated, of whose responsibility in determining future development we surely need no further proofs (pp. 425-426).

Infantile experiences more or less like this must be universal. Rado hypothesizes that through such experiences, learning takes place that disposes to a general understanding that if the unpleasure of a calamity that has already occurred (deprivation in mother's absence) cannot be repaired by aggressive motor action (kicking and screaming), repair will perhaps occur if a

posture of pained resignation is assumed (exhaustion). Rado goes on to suggest that subsequent childhood interactions build upon, confirm, and elaborate the understanding that has been generated in the infantile sequences of exhausted despair inadvertently rewarded by feeding. Later, for instance, when toddlers are disciplined for some misbehavior, their strenuous objections, rather than winning back the parental approval they fear they have lost, may only incur further punishment. However, when they eventually give up their protests and begin to sob helplessly, a loving reunion occurs.

Rado's descriptions indicate a genre of defense elicited by depressive affect, the basis of which is a fantasy that some form of passivity will reverse the effects of a calamity that has made direct, active pursuit of gratification pointless. Within this general class is a subgroup, identifications, in which the fantasy is that becoming the object, or becoming like the object, will permit gratifications that cannot be achieved through direct action within the object relationship.

To think of Rado's formulations concerning depression, like the concept of identification presented by Freud in *Mourning and Melancholia*, as descriptions of defense against depressive affect is consistent with the point repeatedly emphasized by Brenner: *the anxiety and depressive affect participating in psychic conflict are not necessarily to be equated with a patient's manifest fears and despairs*. We often encounter situations in which a patient may be conscious of intense fears connected with inhibitions, but the motivation for those inhibitions involves a different set of worries, quite separate from the ones of which the patient is aware. Similarly, the implication of Freud's and Rado's insights into what we usually call depression is that the dejection and pessimism that are painfully conscious for the patient can be part of a defensive effort designed to eliminate the unpleasure of a depressive affect of which the patient is not in the least aware.

In order to clearly present my conceptualization of two complementary affect-defense configurations, I have had to be

somewhat schematic. I have described what in principle is a dichotomy, but in practice is observed as a continuum. The distinction between defense against anxiety and defense against depressive affect, like the underlying distinction between the two affects themselves, is one that can be made for heuristic purposes, although the idea of a future calamity and the idea of a calamity that has already occurred cannot be absolutely separated: when someone feels the pain of a loss that has already happened, part of that pain consists of concern about what the future will be like without the thing that has been lost; and when someone fears that harm could come in the future, that fear is based upon a wish to avoid repetition of something previously perceived as harmful.

Upon examination, any symptom—or in the psychoanalytic situation, any resistance—inevitably proves a fabric of closely interwoven motivations, including various anxieties, depressive affects, and defenses against them. For instance, Anna Freud (1936) described Little Hans's use of denial in fantasy as part of his horse phobia. If we look carefully at what analysis of the phobia revealed about its components and their functions, we see that Little Hans dealt with his castration anxiety, fear of a future calamity, by inhibiting himself. He stopped going out into the street where he might encounter horses; he became less rambunctious; he generally restricted his motor aggression and burgeoning phallic sexuality, retreating into passivity and anal preoccupations. At the same time Little Hans used the fantasy of being bitten by a horse, to deal with a calamity that had already occurred, namely, that a beloved parent had assumed the position of an enemy. Had Little Hans not made use of such a fantasy, we might speculate, he would have had to experience depressive affect connected with loss of a valued relationship. The wishful fantasy *per se* did not spare him castration anxiety, which in any case had to be defended against by inhibitions.

Because behavior is so complexly structured, if we speak of a focus during one phase of analytic work on inhibition elicited by anxiety, versus a focus during another on enactment of wishful

fantasy elicited by depressive affect, this can only indicate predominant trends. Within any phase, many microscopic oscillations certainly occur; and much time is spent in analysis of aspects of resistance that apply equally well to anxiety or to depressive affect when it is not clear which of the two will eventually come into focus as the analysand's most immediate concern. With this in mind, I would like to turn to an account of clinical events.

CLINICAL EXAMPLE

The following report synopsizes the first two years of an analysis I conducted. It is meant to illustrate how I tend to perceive an analysand's resistance in terms of inhibitions elicited by anxieties, and in terms of enactments of wishful fantasies elicited by depressive affects. I think it shows the way an analysand's responses to my interventions determine which of the two affect-defense configurations appears more pertinent to me at a given moment. There are examples of the shift in my analytic focus from investigation of the analysand's efforts to renounce gratifications, to investigation of his efforts to pursue gratifications, and back again, according to whether I had the impression that anxiety or depressive affect was the most important underlying affect.

The analysand was a young architect who was trying to resolve problems he was having at work. Recognized as a brilliant and creative student, he had graduated at the top of his class and gotten a sought-after position with a prestigious firm. There he soon gained the attention of a senior partner whose protégé he became. His work was excellent, and his responsibilities increased rapidly. Eventually, he was put completely in charge of a project. It was now his task to establish an overall conception for the job, rather than to pursue a direction someone else had chosen. Suddenly, he was unable to concentrate and felt devoid of ideas. He became panicky. His career was seriously threatened by his impaired performance.

As a child, the patient had been extremely close to his mother, who had used him as a confidant. Among other things, she discussed with him her dissatisfactions with her husband. The patient had always wondered whether his father, whom he perceived as aloof and unavailable, resented the close relationship between mother and son.

Over the years, his social life had usually been reasonably successful, although he did feel athletically incompetent, lacked confidence in his sexual performance, and was aware of vague doubts about his masculinity in general. He tended always to have a friend whom he looked up to and from whom he took advice. Typically, the friend's girlfriend would be the one my patient secretly longed for, while he felt he was settling for second best.

The same pattern that was evident elsewhere in the patient's life declared itself in his manner of participating in analysis. He was psychologically minded and capable of candid self-observation. Whenever I pointed out something of significance, he pursued its implications thoughtfully. He was carefully attuned to what he inferred, often correctly, to be the hypotheses that informed my remarks. His associations revealed a sincere wish to investigate areas he understood me to find significant. However, when he could not figure out what I thought might be important, he showed little inclination to decide for himself. Either he would ruminate over previously identified themes, or he would report associations without reflecting on them, taking no initiative in finding a direction for analytic work. Clearly, he left it up to me to say where we should head next.

A group of consistent attitudes and behaviors were identifiable throughout the patient's complaints, his history, and most important of all, in the resistance he demonstrated within the analytic situation. In the first dream the patient reported, he was in a foreign city where he saw a woman sitting alone at an outdoor cafe. She was terrific—sexy, intelligent-looking, sophisticated. He was very attracted to the woman and started walking toward her. He became confused. He did not know the

language. What would he say? Which direction did the traffic come from in this country? He could get hurt crossing the street. A handsome older man was there who knew his way around. The patient asked him for help. The man was friendly and seemed to want to be of some assistance, but there was something amiss. Was the man attracted to the woman too? Perhaps the man was a homosexual. At that point the patient awoke.

The patient's dream and accompanying associations succinctly portrayed the structure of his problem, with obvious references to his transference to me. He wanted to get involved with a desirable woman, but was afraid of being humiliated or even killed. As a result, he abdicated his capacities and deferred to a rival. From this point of view, the picture was of inhibitions elicited by anxiety. There was also the fantasy of impending homosexual submission that woke the patient from his dream. He was unable to speak the language, did not know how things worked, and wanted to receive from someone who possessed them the skills that he himself lacked. From this angle, the patient's loss of function was a calamity that had already taken place, one which he was attempting to reverse through enactment of a wishful, magical fantasy.

The initial phase of analytic investigation looked into the possibility that what the patient experienced as conditions of helplessness, outside his control, might result from decisions he made without being aware of doing so, decisions not to perform because he believed performance to be dangerous. Thus, for example, when he felt devoid of ideas at work, it might be that for reasons not yet clear he was afraid to let himself come up with ideas. Perhaps in the same way he had held back from trying to be a good athlete, and from going out with the women to whom he was most attracted. The foreign city in his dream reminded him vaguely of London—therefore, he could, in fact, speak the language of the country. In the dream, at least, his belief that he was incapable represented an abdication of his capacities.

We became interested in specifying more exactly the kinds of situations in which he was unable to function. Why was it that he seemed paralyzed whenever he was in charge and had a chance to be independent and show that he could be original? A great many interesting and apparently valid ideas emerged in connection with our consideration of these questions, including a number of relevant memories, yet they remained somehow isolated from feeling. The patient described a childhood belief that he had struck a tacit bargain with his father, by which it was all right for the patient to be close with his mother as long as he remained boyish and unmanly. Also, a view came to the surface that his mother's love for him was conditional upon his being an extension of her, a son who remained in close touch and reflected credit on her in the ways she found important, one who did not become too preoccupied with things in which his mother could not participate. However, I could not escape the impression of a sterile, overintellectual quality to the material.

This initial phase of inquiry was guided by the hypothesis that the patient might be inhibiting himself in order to deal with anxiety. As our efforts continued, I felt more and more that our investigation was missing something essential. Much of the intriguing and undoubtedly important material produced seemed to me to reflect an unchanging, subtle, and pervasive compliance. Of course, the core of our analytic efforts had consisted of an attempt to understand the compliance itself as an inhibition designed to deal with anxieties arising within the analytic situation. Most of all, it was our lack of compelling insight into this central feature of the patient's relationship with me that convinced me that something was for the moment eluding us.

For instance, when I called his attention to the way he seemed to hang back and leave it to me to take the lead in our work, he agreed and began dutifully to identify new points for consideration. He presented ideas about being afraid I would feel he was challenging me, of fearing that he would lead the analysis astray, thoughts of various transferences that would explain these attitudes, and so on. Unfortunately, this proved to be the

same old wine in new bottles—intelligent, thoughtful, psychologically sophisticated, but essentially an attempt to give me what he thought I wanted, rather than an authentic expansion of his self-observation. If he was struggling to overcome inhibitions, there was no real evidence of anxiety emerging as a result; nor could I see that in the process we were gaining any fresh understanding of what underlying impulses might be involved in the conflict.

Because this approach to looking at the patient's resistance and his experience of the analytic relationship was proving unproductive, my focus began to shift. It still seemed to me quite likely that the patient's passivity was the outcome of inhibitions designed to defend against anxiety. However, the anxieties were apparently sufficiently compelling, or his motivation to proceed in the face of anxiety sufficiently limited, that analysis of inhibition and anxiety was impossible for the moment. His lack of capacity for active performance in certain areas, even if based on irrational fantasy, had become a *fait accompli*. His experience was not of avoiding a future calamity, but of dealing with a calamity that had already occurred.

The more I realized that this was the patient's state of mind, the more I began to look for enactments of fantasy aimed at repairing calamity. I began to concentrate on the gratifications he was deriving from our relationship, rather than on the gratifications he was relinquishing within it. Instead of thinking about how he might be abdicating capacities he possessed in order to avoid calamity in our relationship, we became interested in how he attempted to acquire from me capacities he believed he lacked. Our emphasis shifted from analysis of defenses elicited by anxiety to analysis of defenses elicited by depressive affect.

I was able to point to a timeless quality in the way the patient experienced analysis, his comfort with what we were doing, despite the lack of any significant change in the symptoms from which he had sought relief in coming to treatment. What was his vision of the future if this continued? What was he hoping

for? At first he responded in an expectable way, as he thought a good analytic patient should: he understood that analysis takes time and hoped that eventually we would be able to reach an understanding that would provide him with the therapeutic benefits he was looking for. But he could not avoid recognizing that this conscious understanding did not altogether account either for a certain complacent patience on his part about the outcome of his analysis or for the satisfaction he took from our relationship.

He developed a fantasy that I was dissatisfied with the progress we were making and was preparing to end our meetings. Looking at this idea, he could see that the important matter was really not whether I was satisfied, but why he would be satisfied with an apparently non-progressive treatment. It occurred to him that, one way or another, our relationship would not last forever, and this realization was upsetting. Gloomy moods began to characterize the last session of the week, and he felt sad about my vacations in a way that went beyond what he could explain to himself on the basis of our work being interrupted for a few weeks.

Eventually, a group of magical ideas came to light, a fantasy of cure that had little to do with the objective facts of the analytic relationship, but was based instead on a belief that I possessed a masculine power I would instill in him in the course of our meetings. In its most successfully rationalized version, the fantasy was that he could infer from various of my remarks how a real man saw things and acted. A series of dreams contained images of airplanes towing gliders into flight, wilting plants being nourished into vigorous health, and the like.

When I would speak after having been silent for a time, he sometimes experienced a startle response. Analysis of it led to awarenesss of thoughts about his body and ultimately to acknowledgment of genital sensations, accompanied by the feeling that I had penetrated him and had begun something growing inside him. Associations to this feminine pregnancy fantasy brought back memories of a frightening prepubertal

episode when he felt sexually attracted to his admired three-year-older brother—a sibling who until this point in the analysis had remained only a background figure.

This second phase of analytic work was concerned with the patient's defenses against depressive affect as the most immediate resistance. He had been using his relationship with me to enact wishful fantasies of passive rescue in a way that severely impeded his ability to look at himself. When these fantasies were exposed and tested against reality, they lost their power to defend against the depressive affect that had elicited them. As a consequence, the patient experienced an overwhelming sadness and sense of inadequacy that was quite different from his presenting complaint of feeling helpless.

We were now able to delineate more accurately his ideas about being less than a man, and to begin to investigate their origin. The patient's relationship with his older brother proved to be very much more important than we had previously appreciated. It appeared that his father was a reserved man, much absorbed with perpetual business problems, and less available than he might have been. In his childhood efforts to differentiate himself from a somewhat overattentive mother, the patient had looked primarily toward his older brother for masculine inspiration. Therefore, the conflict between love and rivalrous aggression associated with the oedipal situation had been felt much more intensely in the sibling relationship than via-à-vis the father. The older brother was in many ways affectionate and well intentioned, but was only a child himself, and therefore, inevitably, too competitive and concerned with his own needs to serve as an optimal father surrogate. Instead of encouraging the patient to feel independent and a grown-up man in his own right, his brother cultivated him to be a devoted admirer, one whom the older brother would favor and protect in return for having his own superiority constantly acknowledged.

At this time another shift in focus was taking place. Analysis of defenses in relation to depressive affect, especially the enactment of wishful passive fantasies within the analytic relation-

ship, had unveiled for examination the patient's conviction that he was defective in comparison to his older brother. As a result, it became possible to investigate how the feeling of being defective was determined by my patient's belief that it was necessary for him to remain inferior in order not to lose his brother's love and in order to avoid being attacked by his brother. In other words, the paradigm of inhibition as a defense against anxiety could now serve as a productive guide to analytic investigation in a way that had not been possible earlier. As the work of this third phase proceeded, a host of submissive trends were played out within the analytic situation and were examined. Genetic determinants included not only homosexual urges toward the patient's brother and father, but appeasement of a jealous, dangerous mother, sometimes perceived as castrated, sometimes as phallically omnipotent.

DISCUSSION

The material I have presented is commonplace, and the sequence of events recognizable to any clinical analyst. For purposes of discussion, I have divided it into three phases. During the first, my analytic efforts were based on an implicit view of the analysand's inhibiting himself in response to anxiety. This proved relatively unproductive as long as his deferential attitudes and behaviors toward me remained unelucidated. The second phase consisted of a shift toward understanding his resistance more in terms of enactment of wishful fantasy elicited by depressive affect. Deference to me was addressed as a submission from which the analysand expected to gain powers he lacked. This analytic approach was more successful. The hours took on a richer and more varied emotional tone. Analysis of defensive enactment of magical rescue fantasies led to the emergence of underlying depressive affect in the form of an overwhelming sadness associated with the idea of being utterly inadequate as a man. Unveiling the analysand's image of him-

self as defective permitted the inauguration of a third phase, during which the paradigm of inhibition in response to anxiety became more relevant than had been the case initially. The contribution made by his transference of his relationship with his older brother could be appreciated as it had not been previously. It became clear that the analysand believed lack of independence and success was the price he had to pay for my goodwill and interest, as a result of which he severely limited his pursuit of competitive and creative satisfactions within the analytic situation.

It appeared that analytic progress required me to come more into line with the analysand's conscious experience by shifting my analytic focus to defenses against depressive affect, moving our work into what I have designated a second phase. By speaking of the productivity of this second phase in contrast to the first, and of the productivity of the third phase that followed, in which defenses against anxiety again became the focus, I mean that increases in the analysand's self-awareness could be observed that were marked by an altered experience of the analytic relationship itself, and that his insights into the role of transference in his mental life were associated with greater freedom of affective expression. Our analytic work confirmed a specific relation between affect and defense, in that clarification of the analysand's enactments of wishful fantasy within his relationship to me led to the emergence of depressive affect associated with conviction of past calamity, of having been damaged; whereas the work we were eventually able to do in relation to his inhibitions brought forth anxiety—unpleasurable ideas concerning dangers in the future connected to heterosexuality and competition.

The sequence of events I have described illustrates my experience that the clinical analysis of anxiety and the clinical analysis of depressive affect are both concerned with clarification of unconscious fantasy, but with clarification of different aspects of unconscious fantasy. As Brenner repeatedly stresses, no behavior serves a single psychic aim exclusively. Within a compro-

mise formation, multiple defensive functions can be superimposed. A fantasy in its gratifying aspect can be used to defend against depressive affect, while inasmuch as it is a frightening idea, the same fantasy elicits inhibition. My patient's fantasy of oedipal triumph, displaced to a certain degree onto his important relationship with his brother, consoled him against the established calamity of exclusion from his parents' sexual relationship, at the same time as it generated an idea of the possible future calamity of castration to be avoided through inhibition.

In clinical analysis there is often the choice of whether to address a fantasy in terms of its connection to depressive affect and defense or in terms of its connection to anxiety and defense. Whether one looks at the fantasied reversal of a calamity that has occurred or the fantasied possibility of a calamity in the future is a matter of angle of view. In practice, the question becomes whether to focus on gratifications achieved through the fantasy or gratifications renounced because of it. Although both will have to receive attention, the choice of which to give priority may be decisive in determining whether an analysis goes forward or reaches an impasse.

Microscopically viewed, the wish fulfillment function of fantasy is always to deal with an unpleasurable *fait accompli.* This was Freud's (1900) view. He conjectured that the first fantasy consists of the memory of the breast, recalled by the hungry infant to deal with the fact of its absence. We have learned a great deal about the mind's cognitive and mnemonic capacities; but to my knowledge we have not modified our fundamental psychoanalytic theory that wish fulfillment to deal with a calamity that has occurred is the motive that invokes and organizes use of these capacities, whether in dreams or waking thought. By contrast, inhibition is an alteration of function directed by fantasy, but not in its wish-fulfilling function. The two strands of enactment of wishful fantasy and inhibition can, strictly speaking, be separated, and clinical analysis requires that we consider them one at a time, temporarily, knowing that the understanding of behavior that we ultimately gain will inevitably reveal the two strands to be inextricable.

I believe a current theoretical task is to further integrate somewhat separate lines of thought that were developed successively in the evolution of psychoanalytic theory. The paradigm that informs the ego psychological theory of psychopathology is inhibition elicited by anxiety. Previously, the concept of enactment of wishful fantasy dominated psychoanalytic thinking about psychopathology. The objective of analytic technique was essentially to unveil an analysand's hidden strivings for instinctual gratification. Early analysts could not think of enactment of wishful fantasy as defense against depressive affect, because the latter concept did not exist at the time. I think it is worth wondering why Freud never revised the formulation of depression presented in *Mourning and Melancholia* in light of his signal affect theory. Perhaps he realized that the new paradigm complemented rather than superseded the one contained in his formulation of depression, and therefore left both in place. Whatever Freud's intention, my own view is that the concept of inhibition and the concept of enactment of wishful fantasy pertain to separate but complementary lines of thought within psychoanalytic theory.

The concept of compromise formation forms a theoretical bridge between the two. However, depending upon how compromise formation is understood, it can be of more or less direct help in the clinical situation. For example, the well-known maxim, "Analyze defense before impulse," does not provide a consistent and reliable guide for choosing between a focus on achievement of gratification and a focus on renunciation of gratification, in my opinion, because *both achievement of gratification and renunciation of gratification can have defensive functions.* I do not see it as particularly useful to conceptualize intrapsychic conflict between impulse and defense. I prefer Brenner's conception of conflict among various psychic *aims.* As Weinshel (1989) points out, Brenner's conception of psychic conflict shows us compromise formation as the outcome of an interaction in which a complex series of components participate. The structural model of the mind is a way of depicting the organization of the components through which compromises are

formed, ultimately subserving the fundamental psychic aims of pursuit of pleasure and avoidance of unpleasure.

I focus on an analysand's achievement of instinctual gratification, via enactment of a wishful transference fantasy, because of its *defensive* function. The same is true when I focus on renunciation of gratification through inhibition of function. For me, the technical question is not so much of impulse versus defense, as of which defense—defense against anxiety or defense against depressive affect? Brenner's concept of depressive affect as a signal that elicits defense permits me to see a role played by instinctual gratification throughout compromise formation, serving avoidance of unpleasure as well as pursuit of pleasure.

For purposes of following clinical analytic process, I find it useful to keep in mind the technical choice between focusing on inhibition in response to anxiety or on enactment of wishful fantasy in response to depressive affect. My experience giving and receiving clinical consultations is that technical problems not infrequently take the form of lopsidedness with regard to this choice, such that an analyst winds up emphasizing a patient's efforts to achieve gratification at the expense of sufficiently understanding the patient's need to renounce gratification—or vice versa. Obviously, this can occur for case-specific reasons as well as because of a more constant bias in the analyst. The example I presented earlier from my own work illustrated how analytic progress requires the analyst to identify and correct his overemphases on one side or the other.

The idea of an alternation between analysis of each of the two affect-defense configurations also points to a possibility for more systematically taking account of what we often refer to as "dosage" or "titration." I think most analysts would agree that a progressive analytic process, like any other developmental learning process, depends upon an optimal series of frustrations and gratifications. How, exactly, this takes place is another important area in our theory of technique yet to be completely worked out. Few would favor the view that the analyst deliberately frustrates and gratifies the analysand, since such manipu-

lative role-playing heads toward the presumption and hypocrisy of a contrived corrective emotional experience. To speak of a therapeutic or working alliance, separate from analytic work per se, but somehow tended by the analyst, avoids the problem of how to describe the causal relation between the analyst's technical choices and the analysand's frustration-gratification experiences.

It seems to me that optimal frustration and gratification of the analysand actually derives from proper execution of the analytic work itself. I think the analysand I presented earlier is typical, in that he tended to be frustrated by analysis of defenses against depressive affect and gratified by analysis of defenses against anxiety. When I exposed his enactments of wishful fantasy, he felt I was taking something away from him; whereas when I pointed out his inhibitions, he experienced me as implicitly promising the possibility of greater satisfaction. The factors that determined my shifts in focus back and forth as the analysis proceeded determined at the same time a sequence of frustrations and gratifications for the analysand.

CONCLUSION

As a final point, I would like to underline that the two affect-defense configurations I have presented, related to the choice between focusing on an analysand's renunciation of gratification or achievement of gratification within the analytic situation, comprise only one of many possible ways of dichotomizing, for heuristic purposes, certain important observations that are within every clinical analyst's experience.

I agree with Wallerstein (1988) that the commonality among diverse psychoanalysts consists of the fact that everyone struggles with the same clinical situation and certain problems inherent in it. The very different conceptualizations we form can lead to important differences in our clinical work. Nonetheless, we all face the difficult scientific task of trying to observe in

an orderly way how we make our technical decisions. My intention has been to expose and systematically formulate trends in my own clinical thinking about the analysis of resistance, the relation between affect and defense, the dialectical interchange between an analysand's subjective experience and an analyst's analytic activity, the investigation of instinctual gratifications and of defenses in analysis, and the determination of frustration-gratification sequences within the analytic relationship.

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The Uses of Moral Ideas in the Mastery of Trauma and in Adaptation, and the Concept of Superego Severity

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THE USES OF MORAL IDEAS IN THE MASTERY OF TRAUMA AND IN ADAPTATION, AND THE CONCEPT OF SUPEREGO SEVERITY

BY ERNEST KAFKA, M.D.

The power of moral ideas, here equated with superego strength, has been explained in increasingly complex terms over the course of the development of psychoanalysis. At first regarded mainly as useful in opposing oedipal instinctual demands, morality came to be seen also as opposed to aggressive wishes while at the same time capable of gratifying aggressive and libidinal forces. In this paper, I discuss the contribution to the strength of morality that comes from the effects of painful ("traumatic") experiences and from the use of moral ideas for social, adaptational purposes. In addition I consider the possibility that unchanging moral ideas can have changes in function in clinical work. A case is presented to illustrate these points.

Ideas about superego functioning have changed during the course of the development of psychoanalysis. I believe it would be useful to add to our more familiar understanding of morality a greater appreciation of its role in the mastery of certain kinds of trauma and its adaptational use in entering into some varieties of social relationships. Such an emphasis is not intended to supplant our view of superego functioning in respect to instinctual control and socialization, but to expand our clinical under-

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A version of this paper was presented at a panel entitled "Superego: Too Much? Too Little?," Helen Meyers, M.D., chairman, at a Regional Meeting sponsored by the N.Y., N.J., Pa. Regional Council at Mohonk, New York, May 1988.

standing of its complexity. In the course of my exposition, I shall also call into question what I regard as obsolete notions about superego severity, particularly references to such simplistic ideas as there being such a thing as too much or too little superego—formulations one still occasionally encounters in clinical discussions.

In the period contemporary with and closely following Sigmund Freud's, analysts thought of the superego as a structure of a certain power and fixity, the heir of the oedipus, incorporating parental injunctions. It could be evaluated as appropriately strong, overstrong, or too weak—or alternately first one and then the other—according to judgments about how much conscious and preconscious suppression and unconscious repression of instinctual drive derivative forces was deemed appropriate. Many thought that analysis consisted in dissolving a transference neurosis that reproduced an infantile neurosis, a process aimed at resolving oedipal conflict. To relieve the patient of some of the excessive pressure of moral injunctions emanating from the superego was regarded as one aspect in achieving the therapeutic aim. Knowledge and the generalizations of psychoanalytic theory about psychopathology and its causes then were not the same as knowledge and theory are now.

An excerpt from Freud's *Outline of Psycho-Analysis* (1940) can serve as a reminder of the way in which Freud preferred to formulate the question near the end of his life.

> The picture of an ego which mediates between the id and the external world, which takes over the instinctual demands of the former in order to lead them to satisfaction, which derives perceptions from the latter and uses them as memories, which, intent on its self-preservation, puts itself in defence against excessively strong claims from both sides and which, at the same time, is guided in all its decisions by the injunctions of a modified pleasure principle—this picture in fact applies to the ego only up to the end of the first period of childhood, till about the age of five. At about that time an important

> change has taken place. A portion of the external world has, at least partially, been abandoned as an object and has instead, by identification, been taken into the ego and thus become an integral part of the internal world. This new psychical agency continues to carry on the functions which have hitherto been performed by the people [the abandoned objects] in the external world: it observes the ego, gives it orders, judges it and threatens it with punishments, exactly like the parents whose place it has taken. We call this agency the *super-ego* and are aware of it in its judicial functions as our *conscience*. It is a remarkable fact that the super-ego often displays a severity for which no model has been provided by the real parents, and moreover that it calls the ego to account not only for its deeds but equally for its thoughts and unexecuted intentions, of which the super-ego seems to have knowledge. . . . The super-ego is in fact the heir of the Oedipus complex and is only established after that complex has been disposed of. For that reason its excessive severity does not follow a real model but corresponds to the strength of the defence used against the temptations of the Oedipus complex (pp. 205-206).

Today, influenced by clinical experience and by the thinking of such writers as Anna Freud (1936) about sublimation, Heinz Hartmann about adaptation and change of function (1939a, 1939b), and Charles Brenner (1982) about compromise formation and affect theory, we would not describe the functioning of the superego in quite this way. We would not think that the superego functions exactly like the restrictive parents, simply as a means of taming the instincts, that it is established only after the oedipus complex has been disposed of, or, for that matter, even that the oedipus complex is disposed of. We are less likely to state that some agency is too strong or too weak, or to emphasize fixity, without also adding that even relatively consistent arrangements are plastic and changeable, both in their outward appearance and in the functions they subserve, even when the forms seem to remain unchanged.

This is so primarily because increasing clinical experience has taught us more about the many forces that are involved in con-

structing psychic arrangements. This increased knowledge has informed us that insofar as the superego is concerned, morality has more sources and uses than those that were emphasized when the structure, superego, was first introduced. I suggest that the judgment about the appropriateness of the strength of moral injunctions be not only based on consideration of defensive needs that oppose oedipal drive derivatives, but also take into account the fact that morality plays a part in response to trauma and in carrying on social relations as well.

Brenner wrote (1982), "Hartmann et al. gave the simplest and most concise definition of the superego. They defined it as the aspect of psychic functioning that has to do with morality" (p. 123). In Brenner's words, "The compromise formations that make up the superego form the basis of the moral aspect of psychic functioning." It is in this sense that I use the term, superego.

A major addition to the understanding of the power of the superego arose with new attention to the problem of aggression. Defense against the temptations of the oedipus complex took on a larger meaning than it originally had, once the vicissitudes of aggressive as well as of libidinal drive derivatives were included under the heading of temptations.

Investigation of patients with depression, negative therapeutic reactions, and self-injuring tendencies led Freud and others to an appreciation of the power of unconscious feelings of guilt and associated wishes for atoning and ingratiation. In the first descriptions, the superego was the structure that arose from the sexual strivings of childhood and their resolution through the creation of moral imperatives that permitted the socialization of the child first in the family and then in the larger social context.

Then, hostile aggressiveness, both innate and consequent to stimulation by humiliation or traumatization, came to be seen as defensively opposed by and at the same time gratified through ethical self-punitive trends. Thus, aggression came to be included as an aspect of the superego (Fenichel, 1928; Nunberg,

1926) which not only functioned to maintain moral standards in opposition to sexual wishes, but also opposed aggressive wishes and could "sadistically" gratify aggressive inclinations by being "excessively" punitive. Quantitative considerations, in terms of the judgment of "too much morality," were related to the need to counter and gratify powerful aggressive as well as powerful libidinal wishes. Experiences of seduction and frustration increased the intensity of instinctual pressure. "Too much" morality was still ascribed to the superego in some cases.

Another addition to the list of forces influencing the severity of superego pressure was the desire for receptive libidinal gratification. Submission to moral commands could gratify this wish. This was the "masochism" of the ego (Loewenstein, 1957). Despite the growing complexity of the analytic understanding of defensive and instinctually gratifying uses of morality, a certain persisting simplicity of viewpoint still allowed analysts to think in such terms as a conflict characterized by excessively strong defense, or aggression, or harshness of moral force. This was so when other uses of morality besides defense against and gratification of instinctual drive pressures were underemphasized.

One of these additional uses of morality was suggested by Freud (1926) when he wrote, in *Inhibitions, Symptoms and Anxiety*, "the value of the object . . . is enormously enhanced" (p. 155). Hartmann expanded the importance of this idea. He wrote (1956), "This conception of ego development is at the origin of much of what Ernst Kris . . . has called 'the new environmentalism' in psychoanalysis. It is the theoretical core for the turning to a closer scrutiny of the impact of object relation on development, and of the ego aspect of object relation, in addition to the earlier consideration of the developmental significance of the libidinal phases" (p. 292). Hartmann felt, with Kris and many others, that observation of the interactions between children and adolescents and their important objects would further clinical and theoretical understanding of development. This renewed interest in object relations led to a greater understanding of the means by which unconscious fantasy, mediated

by behavior whose meaning was also unconscious, gratifies and defends against unconscious wishes by enlisting gratifying responses and support for defense from important individuals in the social context.

Hartmann expanded Freud's emphasis on understanding the interrelationship of the biological individual and the sociocultural environment, by including the study of the behavioral manifestations of unconscious aspects of object relations in his considerations. His concept of adaptation made much of the interrelationship between individual and objects, and individual and institutions. Social institutions, like important objects, influence individuals to modify themselves in the service of the interrelationship while at the same time the institutions are available to be used as supports for defense and vehicles for gratification. Hartmann (1939) emphasized the importance of change of function because this idea was central to his concept of adaptation: "The conception of change of function is familiar in psychoanalysis: a behavior-form which originated in a certain realm of life may, in the course of development, appear in an entirely different realm and role. An attitude which arose originally in the service of defense . . . may, in the course of time . . . come to serve other functions (adaptation, synthesis, etc.) . . ." (pp. 25-26).

An example of a form that remains essentially constant when seen as a behavior or in terms of its defensive use, but which undergoes changes in use and meaning over the course of development, is the ethical principle that the strong ought to help the weak. This idea can further the child's wish to enlist the aid of others in support of her or his often painful, unequal struggle with adults. At the same time, this principle reflects personal fantasy and is also a societally accepted belief. In an adaptational sense, it can function as institutions do. The congruence of the societal ideal and the personal wishful ethic makes it possible to use a moral idea to create alliances with objects. This particular idea can be associated with submissiveness, acceptance of mistreatment, and seeking forms of suf-

fering more tolerable than those that are feared, behaviors that subserve internal psychic defensive purposes and drive derivative gratifications. It can also be associated with interpersonal, real-world adaptive aims.

Stein (1981), in writing about the so-called unobjectionable transference, is one who has applied this sort of thinking in examining transference manifestations whose unconscious sources and uses are sometimes overlooked. He found that "normal" character traits, like the desire to work as an analyst, can function as vehicles for the expression of unconscious forces while they serve to permit a seemingly productive analytic process to go forward. Stein's work suggests that shared moral values, like the moral values motivating analysts to treat patients, have an important use in establishing hidden social alliances between analysts and patients.

For example, analysts in training use shared moral values, often unconsciously, to enlist their analyst's sympathies and support. Analysts can be more or less active in permitting or even fostering an unconscious collaboration that uses shared health values as a basis for concealed aims, such as the wish to enlist followers. Often, patients' wishes for approval can be gratified by such alliances, while at the same time, unconscious motives, such as libidinal and aggressive wishes underlying rescue fantasies in both analysand and analyst, escape attention. Such maneuvers can gratify unconscious wishes and, at the same time, protect resistances in both parties. These considerations indicate that "normal" or "unobjectionable" moral standards play a part as forces in inner conflict and in relating to objects as well.

Another of Hartmann's contributions was to point out that adaptive rearrangements go on as life proceeds. Changes in moral ideas and in the number of functions of those ideas are now more likely to be regarded as important in such continuing adaptive psychic changes than they were earlier.

Another emphasis, really a re-emphasis, is that morality can be used in the service of wishes to deny or otherwise overcome

experiences of humiliation and helplessness. Mastering trauma (in a broad sense of the term) and painful affects consequent to traumatization should take a more significant position in today's thinking, alongside the mastering of impulses. Becoming like infantile objects by sharing their values, including familial antisocial attitudes, often supports suppression of memories of painful experiences at the hands of the parents or others. Submission, taking on parental moral values as one's own, Loewenstein's (1957, p. 203) "seduction of the aggressor," allows the child to use distress to aid in the mastery of past traumatization by turning passive into active, by magically substituting a provoked lesser injury for the feared one, and by avoiding humiliation by manipulating the feared object. Moral obligations can be used to magically enhance the sense of power by assisting in the denial of past calamities and by practically modifying expected future distress.

Excerpts from a case follow. I hope to illustrate the idea that, in addition to the familiar tendencies toward atoning for morally unacceptable wishes, avoiding feared consequences of instinctual wishes, and gratifying aggressive and libidinal wishes, the less familiar factors, such as I have described above, can also enter into mental constructions involving moral trends. I will omit material regarding the understandings of the use of the moral ideas that are well known in order to be able to concentrate on data that will illustrate those uses I think deserve greater emphasis.

I shall emphasize three main points. One is that in the course of continuing adaptation to the social context, moral ideas change, and unchanged morality acquires changing and added uses. The superego is more plastic than we used to think. The second is that morality gains some of its force from trauma and has an important role in the mastery of trauma. The third is that the use of morality in the service of adaptation, in relating to objects, deserves emphasis. I present the clinical material only to support these points and therefore omit much that was important in understanding the genetic and dynamic develop-

ment of the patient, his sexual orientation, castration fears and wishes, and other aspects of his psychic organization.

CASE REPORT

A fifty-three-year-old physician entered analysis because of feelings of listlessness and irritation, which he diagnosed as signs of depression. The absence of pleasure and enthusiasm for life of which he complained had appeared intermittently in the past. The presenting episode followed the defeat of a group of colleagues, among whom he was the senior, in a political battle involving patients' rights, an area in which my patient took special interest. The battle had ended with a decision to draw up standards he thought insufficiently protective of the patients who "were not in a position to do for themselves." This outcome had favored the views of other staff members.

Initially, Dr. M responded by becoming angry. He threatened to accept a position in a competing institution which had offered him more than he had where he was, with a conscious idea of "making them sorry," but he permitted himself to be persuaded to stay. Appeals to his sense of loyalty to the institution that, he was told, needed him, some concessions to him, and a guilty feeling about suffering defeat ungraciously entered into this decision.

"To stay or not to stay, that was the question," he said, and he had taken "the easy way out," by acceding to his moral qualms about being vindictive. Other principles, related to ideals about patient care, had been sacrificed. He had accepted a situation that involved material personal sacrifice as well as the humiliation of remaining in a situation where he had been defeated. On the other hand, to devote himself to the interest of others had been a source of deep satisfaction to him in the course of his life, and he hoped it would prove to be so again. Yet, resentful thoughts had not left him, and he said he had come to realize that he had often, as in this instance, suffered unneces-

sary loss in terms of his own desires because of his moral attitudes. He was unable to understand why it seemed that to benefit others must involve loss to himself. On the surface, his seemed to be a case of too much superego.

The anamnesis revealed that he was the third of three children. A sister, eight years older, had been a disappointment to his mother, who openly complained she had wanted a boy. The patient said the sister played no large part in his current life, except that she made occasional demands, without ever offering him anything in return. He criticized her for having a sense of entitlement without noticing his own tone of mistreatment, or his own sense that doing for others entitled him to a return. While he was aware of his belief that he had a moral obligation to help his sister and believed that he was overly meticulous, to his detriment, in doing so, at this point he was unaware of the great satisfaction he felt in his sense of moral superiority, nor did he recognize the rivalrous feelings that were satisfied through his contemptuous description of her. Further, he was not consciously aware of the implicit invitation he was offering me—to join him in admiring his high principles and in disparaging his sister's character.

A second child, a boy, one and a half years older than the patient, was a difficult infant who later became a violent, impulsive child and often attacked and hurt the patient. The patient remarked that his brother was a needy, sick person, like the parents, for whom he felt he ought to do more. However, his brother spurned his efforts to help, instead treating Dr. M with contemptuous condescension, as he had throughout their lives. The patient continued to present himself as a high-minded, honorable person, superior to both siblings, entitled to, and because he assumed I shared his ideals, likely to get my admiration and respect.

In his early years, the patient was a winning and tractable child, very attached to his mother. He described her as a vain, charming woman, susceptible to periods of withdrawn tearfulness and of outgoing seductiveness, which she exercised in the service of an ambition for social climbing. The patient thought

he was used as a vehicle for this ambition, a role which he generally accepted. He accepted his mother's encouragement to perform for her as a tidy, well-behaved, unaggressive child before her friends, by meekly accepting her enrolling him in socially useful dancing classes, summer camps from the age of five, and prep school at the age of eight, and by allowing her to use the connections made by him with the children of socially desirable people to ingratiate herself with what she regarded as higher types.

The father was presented as a successful consulting engineer from a lower-class background, uncultivated, and an embarrassment to Dr. M's mother, but tolerated as a necessary factor because the money he earned made it possible for the mother to pursue her social aspirations.

The father was aloof and distant and absent from home for weeks at a time. The patient could remember no personal contact with him, but could recall feelings of intense resentment and jealousy when his parents went off on vacations, leaving him behind in the care of servants, or when they went out for evenings. He had many memories of sitting and watching his beautiful mother, dressed in underwear, putting on makeup and trying on dresses, and asking his opinion about what she should wear. And he remembered subsequent feelings of anger and loneliness when his closeness with her was interrupted because she went out with father, returned from a trip, leaving him alone with his brother, who then took the opportunity of teasing him and hitting him. These memories dated, in his opinion, from the age of two or three.

A significant change in his manifest personality occurred when he was five. At that time, a nursemaid to whom he was very attached and who, with a family houseman, functioned as an affectionate and undemanding family within his family, married the houseman and left the family's employ. It was later revealed that she gave birth shortly afterward. He had no memories indicating that he knew of her pregnancy or involvement with the man before this time.

Following this loss, the little boy was no longer so charming,

enthusiastic, and humorous as he had been. He became withdrawn and had a succession of nightmares in which he was buried alive with no one to help him. A few months later, an uncle, a public health officer who worked abroad, visited. Dr. M began to have ambitions to become a missionary in order to minister to the needs of neglected "savages," just as the uncle had done.

His manner in presenting this history was ingratiating, and he also made it clear that he believed that the strong ought to care for the weaker, that such behavior earned one the right to be treated similarly by others, that others' failure to behave according to his ethical standards deserved to be condemned, and that he was entitled to be rewarded for his high moral intentions. During the initial months of the analysis, as he talked mainly about his work, his colleagues, and his relationships, he continued to manifest a respectful, but covertly demanding attitude. I thought his manner was intended, in the main, to enlist my sympathy and admiration for him, and to influence me to ally myself with him in opposition to those he pictured as mistreaters. I was to minister to him, as he had wished his uncle to do, as he ministered to his patients, the descendants of the "savages," as a reward for his good behavior.

The period of suffering at the age of five came back into focus after the patient saw me driving. He responded by criticizing me for having an expensive car and expressing disappointment that I was not more modest in my personal life and more dedicated to helping others. He complained that the fee was more than he could afford and noted that he himself often charged little or nothing. A brief period of anger with me was followed by aggravated feelings of depression and self-criticism focusing on his own felt insufficiency of concern about patients.

I tried to make him aware of the connection between his moralizing and self-derogation, and his feelings of pain, competitiveness, and resentment, parallel in current life to the situation, now remembered, at age five. He wanted what others had, felt powerless to acquire it for himself, and claimed the right to

have more provided for him. When I did not accept and support his right to admiration as the mistreated but morally superior person, he tried to use his goodness to make me feel guilty. His self-criticisms represented self-punishment and also renewed efforts to ingratiate himself with me, or to threaten me, in order to arouse my sympathy and support for his wish to be good.

Feelings of depression persisted. He thought about the many advantages he had had in life, including the possibility of being analyzed, of which he made little use. He apologized for being boring and critical of me, and said that he had felt the same way during other periods of his life.

One such period, which came to occupy his thoughts, was the time when he was sent to boarding school at age eight. Masters had taken an interest in him, but he had not appreciated them. Probably, their attitude toward him was more distant and official than he wished it were and needed it to be. He indulged in masturbation with a fantasy of being adopted by a schoolmate's father, supplanting the schoolmate in his father's affections, and performing fellatio on this man. The need to be thought so good seemed connected to guilt about these sexual and rivalrous wishes. This interpretation had no apparent effect on the course of his ideas.

He continued. He had spent Christmas of that year with this boy's family while his own parents were away on one of their vacations, and had likened himself to Scrooge, who had been abandoned by his parents during a Christmas vacation as a child. His friend's family's reading of *A Christmas Carol* and the happy atmosphere in their home seemed to emphasize his Scroogelike character as it stimulated his resentment of their Cratchit-like happiness, from which he felt excluded.

I related this material to his transference fantasies that I would do more for him if he could either persuade me that he was a good, that is to say, compliant, patient, or if he could make me feel guilty about doing too little to alleviate his distress. He became angry and sullen about one of my vacations,

came to sessions late, failed to pay on time, and redoubled his efforts to be a helping person.

On the one hand, he reported a change in his attitude at work. There, he felt happier and more productive and saw that his political activities had been carried out in a provocative and self-defeating way in the past. Now his views seemed to have more influence. On the other hand, he continued to feel very guilty, reported that he seemed to be drinking a great deal, and revealed homosexual activities. I suggested that he continued to wish to show me how good he was and also wanted me to feel responsible for his condition in order to punish me, to elicit affectionate help, and to avoid memories of his past sufferings. This last comment seemed to have the effect of enhancing his capacity to inform me of important feelings and ideas.

The history of his sexuality was now expanded. In adolescence, he had practiced mutual masturbation with a roommate. In college, he had had several sexual relationships with women, by whom he felt used and toward whom he felt guilty because he thought he seduced them without affection or interest in them. After college, he had fallen in love with a man with whom he continued to have a close relationship even after this man's marriage. After his friend's marriage, Dr. M tried to befriend a former professor whom he regarded as an ideal of ethical behavior. When the professor asked him if he were homosexual and made it plain that an intimate relationship with the patient, who desperately wanted to be thought of as a beloved son, was impossible, Dr. M underwent a period of grief and anger. At that juncture his current sexual behavior commenced: he picked up teenage homosexual prostitutes whom he befriended, lent money, and encouraged to become heterosexual. He also made a conscious decision that henceforth he would be self-sufficient and never cry again, as a moral principle. Interpretation continued to focus on the various means he employed to try to avoid painful memories.

He was surprised when his associations turned to his description of his relationship with his mother during and after the

period just after college. His homosexual love affair seemed to have followed his discovery that his mother had been hospitalized for a depression. At first, he made efforts to arrange medical care for her but soon realized she preferred his father's care. He suffered a sense of disappointment but did not cry. Three years later, the father died, and the patient then assumed the role of his mother's caretaker, running her household, paying her bills, and managing her investments and medical needs.

Over the course of some weeks I made various interpretations having to do with what I thought I understood at the time. It seemed to me that the father's death had come at about the time Dr. M's lover had married, that his effort to find a new father had represented a response to this event, as much as to the loss of the sexual relationship with the lover, and that his caretaking attitude toward his mother, while continuing a long-standing wish and behavior toward her, also represented a wish to be a woman and mother himself. The patron who disappointed him was to be the father, he, the mother, and his mother, the child. His attitude toward homosexual prostitutes and toward me in the transference now reflected the wish to be fathered and to act as mother, in order to reverse the situation in which he had felt seduced and frustrated by his mother and in order to atone for his guilty wishes about destroying and replacing his brother and father. The continuing effort to distance himself from the painful experiences of his childhood by adopting the missionary, parental role in association with admired others and by attributing the sick, needy, savage qualities to others seemed most important, as did his use of morality to create supportive relationships and assist him in his efforts to see himself as powerful provider.

This interpretation had the effect of producing tears and feelings of great sadness. Over a period of months, the patient reported experiences of grief related to what he now saw as his great feelings of deprivation and loss in connection with both parents. For the first time, their vacations, their sending him to

boarding school, his mother's building him up to feel vital and loved but repeatedly demonstrating that she preferred his father, her friends, or her beauty, all appeared to him as deprivations and unbearable losses. His drinking increased as did his manifest rage with me. I was blamed for taking his love for his mother away from him, for leaving him without anyone, and for destroying his belief that at least one element in his sexual behavior, the wish to do good to the prostitutes, reflected only altruism. Further, my interventions had broken his determination not to cry.

I responded in various ways. One was to maintain that it seemed that his morality, his self-castigation for being envious, jealous, and insufficiently altruistic, had served to punish him for the feelings of resentment and destructiveness of which he had been aware, but that they had also had the important function of helping him avoid the experience of feelings of humiliation and helplessness in his past. Another was to ask whether one of the motives for his drinking was to help him suppress his sexual feelings. I suggested that his seemingly moral principle, to place others' interests before his own, enabled him to suppress wishes that he feared.

Subsequent to this work, the patient's associations in the analysis again came to center on events of everyday life. He spoke of his continuing, generally gratifying functioning at work, of the growing appreciation of his administrative ideas among colleagues, of his anticipation of promotion, and about problems with patients with which he seemed generally able to deal to his own satisfaction. However, after a few weeks he began to fall silent for unusual periods of time. He had a confession to make. He had joined a church-associated support-discussion group and was certain that I would disapprove. I might find some way of showing him that this involvement was, as previous involvements had been, something that he would have to give up. He had to confess to an almost sensual feeling of contentment at his meetings where he could reveal his feelings, his strengths, and

his weaknesses to others, and accept those that others reported. Perhaps, like his mother, I would reject him if he revealed his pride in himself or his interest in others.

I wondered whether he felt a particular difficulty in revealing the sensual aspects of his feelings, given the fact that he had recently come to be able to feel more satisfaction in his accomplishments and to report his self-satisfaction to me.

He replied that he had a further secret to report. One day I had mentioned feelings of humiliation. He had not understood what I meant. Perhaps the following night, or one night soon after, he had dreamed his mother was alive and young, and he felt attracted to her. As a child, he remembered sexual feelings toward the maid and even toward his mother. The maid had responded in a kindly way, but his mother had shown disgust. He had indeed felt profoundly humiliated and embarrassed but had forgotten these early events until, in adolescence, he informed his mother that he had ejaculated for the first time. She indicated that she wished to hear nothing of this. He again felt humiliated and rejected and suddenly remembered his childhood experience. When he confessed the story to a priest, the priest was shocked and horrified. Guilt about such feelings had followed him ever since. He feared that revealing such feelings to me might lead to similar shock and horror on my part. On second thought, he added, his attitude about sexuality, his own and others', about ethics, and about the behavior of his colleagues had undergone significant change. He no longer thought these sexual, competitive, and possessive desires were so disgraceful.

Not only had his moral ideas changed in becoming less rigid and more related to particular circumstances, but also, he thought, ethical considerations had come to have more to do with questions of what might help others than with uses having to do with assuring himself of his own goodness, independence, and powers. On further consideration, he thought that an element that he wished to discuss, but was hesitant to bring up, was

separating from me by terminating the analysis. Now, in discussing this, he thought that, perhaps, no longer being a boy unable to perform like a man, he no longer needed to claim that his desires were evil and selfish because they were doomed to frustration. He added, "The desire of youth had defined what was virtuous." Perhaps now he could consider ending the analysis with less guilt and fear.

DISCUSSION

The history of this patient's character development as it became clearer to him and to me during the course of his analysis reflected continuing change in his moral ideas and in the uses to which he put morality. The preoedipal period had been marked by a seemingly willing compliance with his mother's wish that he be a good boy. Self-critical attitudes did not occur, as far as we know, until after the remembered traumatic disappointment in the maid and the houseman. His morality then seemed to serve his wish to attach himself to his uncle, and his uncle to him, by becoming like the uncle. This method, designed to enlist outside support by emulating parental substitutes who, he hoped, would thereby come to love and foster him, persisted into his adulthood.

It was only later that he began to *use* being good. He used good behavior in such a fashion that compliance was more apparent than actual, in order to punish himself and others. He came to use his guilt to evoke guilt in others and to show his moral superiority in order to make others feel inadequate. Eventually, his sense of moral superiority and entitlement came to result in frustration and disappointment in life. He provoked rejection and suffered its consequences.

His use of moral ideals to establish himself as a superior person also came to be increasingly supported by his desire to avoid conscious memories of loss and humiliation. Successive

blows strengthened the forces that supported this purpose. What seemed to be morality to him, others more and more often took to be moralizing. His sense of entitlement made it unlikely that others would deal with him sympathetically. The moral behavior that at first functioned as an appeal to others remained effective as a defense against sadness and sad memories, but later it also became a factor that limited his experiences of satisfaction.

A further revision of the use of the consistent, unchanging idea that the weak are entitled to help from the strong took place during the analysis. Then this idea acquired greater force as a guiding principle, as a satisfiable, gratifying ideal. At the same time, its use for ingratiation, provocation, punishment, and avoidance of painful memories from the past lost some power.

Dr. M did not suffer as a consequence of too much superego. He suffered because he continued to use morality in the service of his wishes to forget, suppress, and revise memories of experiences that could arouse painful feelings of humiliation and helplessness. This method helped him limit his conscious distress but did little to allow him to deal with the underlying sources of his suffering. These remained, despite his defensive efforts. In addition, he suffered because he used moral stances in efforts to gain support for his self-aggrandizing wishes, and to punish and threaten those who did not succumb to his attempts to ingratiate himself. These efforts gratified some wishes and had some adaptive usefulness, but they also brought about rejection and retaliation, just the effects that he wished to avoid and that, in another time, had influenced him in constructing those methods in the first place.

That moral ideas are used to mediate relationships with objects throughout life, and that they undergo changes of function throughout the course of development and during psychoanalysis, is evident in my clinical material. The analytic experience resulted in the appearance of new moral ideas, in further

revision of the uses of persisting moral ideas, and in a diminution in some of their uses in this patient.

That morality can be used as a part of defenses against painful ideas of weakness and that it plays an important, often revised, and growing part in relating to the objects through whom sensual and hostile gratification is achieved, is also illustrated by my clinical material.

These observations help us to understand the power of morality, but should not lessen our appreciation of the fact that moral ideas defend against drive derivatives that seem threatening and that they gratify aggressive and libidinal wishes through symbolic means. But I find it helpful to emphasize that both changing and persisting moral ideas have changing functions; they participate in the continuing modulation of one's relation to the social context and help one to modify moods and self-perceptions. When seen as additions to the long-familiar uses of morality, these uses of moral ideas can explain phenomena that were described as consequent to excessive superego strength in the past, when these uses had not yet been sufficiently appreciated.

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The Anatomy of Psychotherapy. By Lawrence Friedman. Hillsdale, NJ: The Analytic Press, 1988. 601 pp.

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BOOK REVIEWS

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THE ANATOMY OF PSYCHOTHERAPY. By Lawrence Friedman. Hillsdale, NJ: The Analytic Press, 1988. 601 pp.

Lawrence Friedman's book includes many of his ideas which have appeared in papers published in analytic and other journals during the past two decades. It is a book about psychoanalysis and its derivative psychotherapies, written mostly from a psychoanalytic perspective. As such, it will be of considerable interest to analytic clinicians and theorists. Given the author's erudition, creativity, irreverent skepticism, and curmudgeonly rhetorical approach, one has every reason to expect a demanding, fascinating, and often entertaining read. Friedman's work does not disappoint.

The author emphasizes that the psychotherapeutic enterprise is difficult and stressful for both its participants. Stress and difficulty are, for Friedman, the mother of invention, in this instance the invention of theory of the mind and theory of therapy. He attempts to demonstrate that Freud's theories, as well as many psychoanalytic revisionist contributions to theory, owe their birth to an attempt to reduce the stress on the therapist and make the therapeutic task more manageable. Similarly, the inherent ambiguities of the therapeutic encounter that lie behind the difficulties and stressfulness of the work require exploration and explanation from multiple perspectives in order to apprehend them, at least temporarily. Friedman approaches his anatomical dissection from many perspectives, including the philosophical, the abstractly theoretical, the clinically experiential, and the humanistically integrative, among others. One sees the same phenomena (i.e., therapeutic alliance, suggestion, transference) illuminated from various vantage points throughout the text.

As this is a collection of manuscripts on different subjects tied together by the author's rhetorical "bookmaking" device—the dissection of the subject of psychotherapy—it becomes the author's task to present a cohesive, readable and integrated whole. He sets out to do this by dividing his work into a variety of sections. He begins from the perspective of the therapist's discomfort. The highlight of this section is Friedman's dissection of the concept of the therapeutic alliance. This abstract clinical entity, almost univer-

sally accepted by psychoanalysts (for an exception, see Brenner[1]) and highly regarded by those who attempt to study psychotherapeutic effectiveness empirically, is examined by Friedman as a construction in the therapist's thinking to explain and at least imaginatively do away with the conflicting interests of patient and therapist and the attendant stress that results. He concludes that the alliance concept is a necessary evil, one which can be constructive so long as its origin in the needs of the therapist remains at least from time to time discernible.

In Section 2, the author turns to what he terms a "naturalistic" description of the two parties involved in therapy, with the specific aim of highlighting the therapist's many actions to maintain his balance or equilibrium in the face of the complexity of forces operative in the therapeutic field. It is Friedman's premise that the resolution of controversies in technique must be understood in terms of "the therapist's reaction and the patient's uptake."

The theory of mind, about which the next section centers, is the third factor in the author's defined therapeutic field. It is there both to ease the strain the patient and therapist are under and to help in making the therapeutic encounter useful. In Friedman's view, the theory of mind is "an expectation of untapped potential" which the therapist and eventually the patient both come to recognize as existing within the patient. The theory of the mind thus plays a decisive role in illuminating "the patient as a functioning entity with hidden possibilities" (p. 150).

The author explores Freud's theory of mind and its historical context, and in the subsequent section examines various revisions of psychoanalytic theory. A central theme in his exploration of Freud's paradigmatic theory of mind is Friedman's position that Freud's objectifying of the mind and of mental processes was more than a misguided application of nineteenth century scientific thinking to mental phenomena. Freud drew a picture of mind as both unitary and conflictual. Out of this seeming paradox, the necessity for abstraction, mental substantives or "experience-distant" constructs, as well as useful metaphor and anthropomorphism, become necessary.

[1] Brenner, C. (1979): Working alliance, therapeutic alliance, and transference. *J. Amer. Psychoanal. Assn.*, Suppl., 27:137-157.

Friedman goes on to explore subsequent revisions of theory as a response to the complexity of Freud's theory, its internal tensions and paradoxes, and the impact of sociocultural and philosophical trends. The revisions also represent a general characteristic of theorizing in relation to complex, only partially explainable phenomena. While respectful of revisionist theoretical and clinical positions, among them those of Schafer, Gill, Kohut, Loewald, George Klein, Levenson, Gendling, and Piaget, Friedman finds none of them to be successful in doing away with the necessarily complex, internally contradictory, multidimensional edifice of Freud's theory of the mind. Friedman successfully shows where these revisions highlight, further clarify, or open up new areas within the body of Freudian theory; he discusses as well their conceptual weaknesses and as yet unfulfilled promises.

Section 5 addresses the ambiguity of the therapeutic enterprise and various "disambiguating postures" of the therapist that constitute, in the author's view, the essence of controversy regarding the theory of technique. He reviews, among others, the hermeneutic position, the contrasts between Schafer's and Gill's different emphases and rationales for clinical approaches, Kohut's technical strategies, and Loewald's integrative efforts. Friedman's views on the hidden wishes of the therapist are particularly instructive. These must be addressed in any comprehensive study of therapeutic technique. The last section of the book attempts a summary or fitting-together view of psychotherapy, examines certain training issues, and ends with a glance at the future of therapeutic practice.

As a book, Friedman's *The Anatomy of Psychotherapy* is more than a mere compendium of manuscripts written over many years. It represents a thoughtful, critical examination of the psychotherapeutic venture from multiple perspectives, without premature closure or adherence to dogma. It does this with a mixed spirit of respect and disrespect that never trivializes clinical or theoretical work but questions certainty about matters uncertain. Overall, this reviewer found the volume successful, rewarding, and important. While longish, and demanding considerable psychoanalytic erudition on the reader's part, it is a treasure trove of thoughtful ideas in which exposition, exploration, and criticism are harmoniously interwoven.

STEVEN T. LEVY (ATLANTA)

FACILITATING PSYCHOTHERAPY: SELECTED PAPERS OF SIDNEY LEVIN, M.D. Edited by Lois A. Levin, Ph.D. New York: Irvington Publishers, Inc., 1987. 229 pp.

Sidney Levin (1912-1981) wrote widely on a variety of subjects in psychotherapy and psychoanalysis. In this privately published book, edited by his daughter, we are given thirteen of his papers. They convey a sense of his varied interests: the psychotherapy of depression, the elderly, college students, psychosomatic medicine, group therapy, marital incompatibility, the psychology of shame and entitlement, and gift-giving to children in psychotherapy. The title of this collection, *Facilitating Psychotherapy*, indicates the practical aim of many of these papers.

The papers are classified under four headings: (1) Affects: Depression; (2) Affects: Shame; (3) Active Intervention Techniques; and (4) Specialized Treatment Interventions.

There are four papers in the first section. "Suggestions for Treating the Depressed Patient" (1965) is a thoughtful, pragmatic approach to treating depression and includes an understanding of interactions in marriages that favor depression in one of the partners. "Separation from Home in College Students" (1967) describes hidden depression attendant to leaving home. "Depressive Factors in Psychosomatic Illness: Peptic Ulcer" (1971) offers clinical illustrations of ulcer symptoms precipitated by depression. The final paper in this section, "The Distribution of Libido in the Aged" (1965) is a sensible account of the psychological impact of physical, mental, and situational changes in the elderly and the need for a "redistribution" of libido to cope with these changes. Levin makes an excellent point in stressing the importance of touch in this age group:

> It is worth noting that the elderly female is usually given greater permission to obtain direct satisfaction of libido by means of bodily contact with children, either through sleeping arrangements or otherwise, whereas elderly males are apt to be considered perverted in either a heterosexual or homosexual direction if they need such contacts. . . . Our Western culture demands a fair amount of restriction of such closeness in everyday life, especially of the aged (pp. 37-38).

The second section, "Affects: Shame," is the centerpiece of the collection. It is comprised of Levin's two papers on shame, "The Differentiation between Shame and Guilt" (1967) and "The Psychoanalysis of Shame" (1971). These papers are replete with ideas. The lively writing suggests the extent to which the subject caught his interest. And the papers are surprisingly timely. Current developments in infant research and affect theory invite a re-examination of shame. Levin's focus on both the constitutional and the experiential (being shamed) provide an excellent framework for a modern study of shame. According to Levin, shame is a "constitutional inhibiting" force (p. 75) (analogous to disgust[1]), a basic unpleasant affect which directs "the sexual drive away from danger" (p. 76) and a "basic component of the normal homeostatic mechanisms regulating libido" (p. 92). "It performs an essential function in the control of impulses and the management of object relations" (p. 92). Libidinal drives (the aggressive drive is related to guilt) must be regulated lest the ego be overwhelmed or the object relationship threatened by excessive self-exposure and rejection by the object. The wish to be totally free of shame "is often associated with the conviction that intense shame is based entirely upon early traumatic experiences, which only have to be brought to consciousness in order for shame to be eliminated" (p. 107). This mistaken conception may serve as a powerful resistance in analysis.

Levin also takes a step toward formulating the dangers of intimacy as he considers the importance of privacy, a subject much neglected by analysts. He cites Freud: ". . . no one can tolerate a too intimate approach to his neighbour."[2] This interpersonal view of affects, their function as regulators of interactions, is central to newer concepts of interactions as described by ethologists and infant researchers. Capacities to control interactions are basic to the development of object relations. An excellent example is gaze aversion in the first months of life, in which the infant demonstrates its ability to regulate eye contact. In later life, poise, which Rangell[3] formulated as "largely a set of active defenses instituted in order to

[1] Freud, S. (1905): Three essays on the theory of sexuality. *S.E.*, 7.

[2] Freud, S. (1921): Group psychology and the analysis of the ego. *S.E.*, 18:101.

[3] Rangell, L. (1954): The psychology of poise, with a special elaboration on the psychic significance of the snout or perioral region. *Int. J. Psychoanal.*, 35:313-332.

protect against shame" (p. 79), may also serve regulatory, adaptive ends.

The third section, "Active Intervention Techniques," contains four papers, three of which seem properly grouped in this section —"Mastery of Fear in Psychoanalysis" (1964), "Counteracting the Tendency To Succumb to Inertia" (1976), and "Undoing Childhood Traumata through Environmental Manipulation" (1974)— in that they emphasize avoidances by the patient, not infrequently based on shame, and they stress the therapeutic importance of addressing these avoidances. The last paper in this section, "The Psychoanalysis of Attitudes of Entitlement" (1970), while misplaced, contains a wealth of interesting ideas. It is a valuable review of the concept of "narcissistic entitlement," with credit to Freud,[4] Jacobson's[5] elaboration of Freud's concept of the "exception," and particularly Murray's[6] influential paper in which the term "narcissistic entitlement" was perhaps first proposed. Levin formulates three types of entitlement: normal, excessive, and restricted. He vividly describes the righteous indignation in everyday life, marriages, and the transference that follows the frustration of excessive entitlement. The inhibited patients are of special interest. They are not masochists seeking suffering but inhibited individuals who do not feel they deserve a good life. This group has been of special interest to Modell[7] and to Weiss and Sampson.[8] Levin also postulates that these patients may suffer from excessive shame.

The final section, Specialized Treatment Techniques, includes three papers: "A Comparison of Psychoanalytically Oriented Group and Individual Psychotherapy" (1963); "A Common Type of Marital Incompatibility" (1969), in which shame and entitlement are significant; and the useful paper, co-authored with Henry Wermer, "Giving Gifts to Children in Psychotherapy" (1966). The

[4] Freud, S. (1916): Some character-types met with in psychoanalytic work. *S.E.*, 14.

[5] Jacobson, E. (1959): The "exceptions." An elaboration of Freud's character study. *Psychoanal. Study Child*, 14:135-154.

[6] Murray, J. M. (1964): Narcissism and the ego ideal. *J. Amer. Psychoanal. Assn.*, 12:477-511.

[7] Modell, A. H. (1965): On having the right to life: an aspect of the superego's development. *Int. J. Psychoanal.*, 46:323-331.

[8] Weiss, J. & Sampson, H. (1986): *The Psychoanalytic Process: Theory, Clinical Observation, and Empirical Research*. New York: Guilford.

latter, one of the few papers on the subject, should be more widely known.

While this personally gathered collection seems a labor of love and respect for an active and productive analyst who contributed much to psychoanalysis, particularly in the Boston area, it is also valuable in its own right. Some of the papers are dated, but the experienced analyst will find the papers on shame, entitlement, and gift-giving particularly worthwhile. The collection, however, may find its greatest usefulness for the beginning psychoanalytic psychotherapist. These papers cover many clinical problems and an age range from childhood through old age. It is a good mix.

PHILIP SPIELMAN (BERKELEY, CA)

THE MIND IN DISORDER. PSYCHOANALYTIC MODELS OF PATHOLOGY. By John E. Gedo. Hillsdale, NJ: The Analytic Press, 1988. 251 pp.

John Gedo takes a fresh, provocative turn in this, his seventh book. From 1973 with *Models of the Mind*, co-authored by Arnold Goldberg, until *Conceptual Issues in Psychoanalysis* in 1986, he has elaborated a clinically derived replacement for metapsychology and sought to redefine the scope of psychoanalytic practice. Many of our best writers have reviewed and debated his work, creating a secondary literature that is in itself an excellent mosaic of recent psychoanalytic thinking.

In *The Mind in Disorder*, Gedo calls for a new, psychoanalytically derived diagnostic nomenclature, arguing that new techniques seem about to demonstrate what is tissue- and chemical-based and what is not, leaving adaptive disturbances to be described by depth psychology. He keeps his earlier conceptual schema, but now focuses more on the autonomous functions, their curtailment or loss, and their involvement in conflict.

"Obligatory repetition" has been a cornerstone of his earlier work. Here he joins it with "apraxia," a failure to attain an autonomous function due to inadequate nurturing or constitutional factors. He uses obligatory repetition and apraxia to account for a range of pathologies; e.g., symbiotic needs are a reflection of failure to attain a necessary skill and will disappear when the patient is suitably instructed. He states that masochistic behavior may

be decisively altered by realizing that the patient does not know any other way to act and showing him alternatives.

In one case example, Gedo instructs a young woman in how to be polite; in another he advises a patient subject to overexcitement to take warm baths. Agreeing that the search for psychosomatic specificity is doomed, he points out the usefulness of the analyst's questioning why some people with stress-related illnesses continue to aggravate their conditions. Other vignettes describe patients unable to monitor somatic integrity, sleep, appetite, and sexual arousal; to maintain an independent sense of reality; to communicate effectively; or to tolerate elation. For a patient who cannot use empathy, the analyst shows and then names ways in which others might react to her behavior.

In the case of a man who could not experience elation without arranging an accident or other mishap, Gedo notes that the behavior stopped when it was pointed out, thereby demonstrating apraxia: he claims that interpretation would have been required for the behavior to stop if self-punishment had been involved. Similarly, obsessional patterns may represent an apraxia in planning goal-directed behavior.

Obligatory repetition, like some of his other terms, Gedo derives not from psychoanalysis but from developmental studies. It begins with sensorimotor, affective components derived from earliest experience, which become part of the foundation of a hierarchial arrangement of goals and values called the "self-system." When external changes make repetition of early affect and action patterns impossible or when change is demanded at too great a rate, various sequelae appear. There may be an acute panic with loss of the sense of personal continuity, or the patient may resort to reversal mechanisms. Gedo illustrates the latter by describing a patient who drove her analyst crazy just as mother had driven her crazy, when his steady, empathic listening prevented her from utilizing her usual ways of self-protectively relating to people. There may be inversion of the action pattern, as in reaction formation, or the adoption of a mode that corresponds to a template of the original. On the other hand, circumstances may fail to elicit the basic repertoire at a sufficient rate, resulting in anaclitic depression; and while the excessive tension of too rapid change is often accompanied by loss of sense of self, anaclitic depression is not. Gedo illustrates

subtle re-enactments of primitive material, reminding us in an aside that with the development of the structural theory, Freud's view of acting out as a substitute for memory became of less interest than what acting out reveals about unconscious ego activity.

Followers of Gedo's work are familiar with the classes of intervention he and Goldberg recommended in 1973 for problems centered in disturbances of early stages of development: "pacification," "unification," and "optimal disillusionment." Interpretation is seen as suitable for later, oedipal conflict. Gedo remains sharply critical of analysts who persist in interpreting much preoedipal material as regressive from oedipal conflict, yet here major diagnostic issues arise. He states that "diagnosis using analytic principles can only be based on the unfolding of a succession of transference constellations in the course of psychoanalytic treatment" (p. 7) and that the analyst must rely on empathy and the observational skills of a natural scientist to assess and to meet the patient's needs in these areas of adaptation. However, having repeatedly insisted that interpretation is futile unless it is preceded by measures that deal with primitive apraxias and repetitions, he indicates that these archaic levels of integration are usually exposed only after some interpretive work has been done. "Diagnosis" here then means a spiraling, constantly revised assessment necessary for day-to-day work, not a judgment whether analysis is the best treatment available. Gedo, in fact, has indicated over the years that with his technique and definition of analysis, almost every nonhospitalized patient can be analyzed.

Gedo uses diagnostic terms as a framework to present a number of astute observations that draw the reader into his theoretical system. He notes that circumscribed areas of thought disorder frequently observed in psychoanalytic practice are often due to reversible regressions rather than to a failure to develop special skills in the first place; but here, too, one encounters true apraxias, such as the failure to develop a sense of humor or the inability to judge between a literal and a metaphorical interpretation. Focal thought disorder is also frequently based on identification with an early care giver. His approach to borderline and psychotic behavior is based on archaic unintegrated cores of function that persist in everyone and can emerge in therapeutic regression, psychosis, physical illness, or traumatic states. He notes instances of people who

function at borderline levels for long periods of time, but who integrate with very little or no treatment if there has been no developmental arrest, while others arrested at a primitive level may have only depersonalization available as a defense.

Gedo notes that the phenomena involved in the psychoses do not capture the earliest stages of development but that traumatic states do. He emphasizes that traumatic states and their sequelae are seen as readily in neuroses as in psychoses. He likens recovery from traumatic states to that from psychosis, each being facilitated by the provision of a safe, simple milieu, control of affectivity through medication or through human contact, the establishment of a human relationship, etc. He notes that when reintegration from psychosis takes place rapidly, we discount its diagnostic significance, or say that it is "hysterical psychosis," rather than accepting what this says about the nature of psychosis. His stress on self-organization fits nicely with his observation that the urgent request to regain a lost self-cohesion can override other motivations. Characteristically, he extends this point further than observation per se allows, claiming that the quest for self-cohesion can overcome even the pleasure principle.

Among stress-related illnesses, Gedo groups the addictions, bulimia, and some sexual perversions, which he views as nonspecific responses to intolerable stress. He offers some particularly interesting observations on masochism and fetishism and on the use of sexuality to reinforce an insecurely organized personality by virtue of its intensely pleasurable affective charge. Again he goes a provocative step further, claiming that childhood sexuality's only function is to buttress self-esteem or lend cohesion to a personality threatened with disruption.

Gedo has reacted against two major influences. One is his nameless teachers of psychoanalysis who refused to acknowledge the importance of preoedipal phenomena as anything but regressive. The other is Heinz Kohut, with whom he broke many years ago but whom he follows in his emphasis on the self and to some extent in his development of a theoretical frame that stresses, in Gedo's case, self-cohesion. Gedo, like Kohut, stresses transitional relatedness in the transference but feels that he has refuted Kohut's claim that empathy or the transmuting internalization of affirmation by an empathic self-object can hold the cohesive self together. In-

stead, according to Gedo, the analyst's appreciation of the apraxias and his providing the patient with necessary skills does away with the need for a self-object.

John Gedo is one of our best writers. Like Freud, he draws the reader into ongoing discussion and arrays the techniques of a skilled lecturer to keep him or her engaged. Succinct, vivid vignettes follow assertions of novel viewpoints, resulting in a fast-paced, highly readable interweaving of clinical observation and theoretical expositon.

The current book uses diagnostic considerations to illuminate the author's previously described theory of self-organization and to expand on his concept of apraxia. It is paradoxical that he uses this well-established neurological term precisely after claiming that diagnostic advances (presumably medical) are about to enable neurology and psychology to part company, a prediction many of us do not entirely share. His new use of the term could only confuse workers familiar with both fields if it were to come into general use.

"Apraxia" as a term is in keeping with Gedo's interest in learning. His epilogue is entitled "The Art of Psychoanalysis as a Technology of Instruction." It is as though, finding Kohut's concept of transmuting internalization wanting, he is wary of all *broad* concepts of internalization and of drive; and he seeks to describe the subtleties of development and of treatment in terms consistent with conventional neurological and learning theory.

Is this psychoanalysis? Gedo anticipates and tries to answer the question. What we can say with some certainty is that he wants it to be psychoanalysis and that every analyst will find much to applaud and something to deplore in this fast-paced, thoroughly engaging book.

DAVID A. CARLSON (NEW HAVEN)

THE MANY FACES OF SHAME. Edited by Donald L. Nathanson. New York/London: The Guilford Press, 1987. 370 pp.

Piers and Singer's *Shame and Guilt* in 1953[1] was a pioneering work on shame. But few investigators followed the trail until the land-

[1] Piers, G. & Singer, M. B. (1953): *Shame and Guilt. A Psychoanalytic and a Cultural Study*. Springfield, IL: Thomas.

mark contributions of Tomkins,[2] Lewis,[3] and Wurmser[4]. Since then, there has been a burgeoning of research on shame by workers in diverse disciplines, including practicing psychoanalysts and psychoanalytic baby-watchers. In spite of the accumulation of an impressive body of knowledge, the importance of shame is ignored in much of the psychoanalytic and psychiatric literature.

Passionately concerned about redressing this neglect, Donald L. Nathanson persuaded his eleven distinguished co-authors to join him in consolidating current facts and theories about shame in one volume. The result is one of the best organized and executed multiauthored works I have enjoyed. It serves as a handbook on the detection and therapeutic handling of shame in its many gross and subtle manifestations. We are offered differing stimulating theoretical insights, but an integrated theory of shame—integrated with the other affects and integrating psychoanalytic and non-psychoanalytic research—is still to be done. Some of the contributions in this volume are more substantial than others, but the least are well written and instructive. I have only one major complaint about the book as a whole: the index is too skimpy for its abundant contents. The references supplied by the authors constitute a splendid bibliography.

Nathanson contributes two chapters: an introduction, "A Timetable for Shame," the longest paper in the volume, and a chapter titled "Shaming Systems in Couples, Families and Institutions." In addition, he provides clarifying prefaces to each chapter. His introduction contains incisive summaries of the work of major investigators. He develops his own version of *modern affect theory* which derives primarily from the work of his chief mentor, Tomkins, and from the work of Wurmser, plus that of psychoanalytic baby-watchers, notably Stern.[5] He gives a fascinating account of facial

[2] Tomkins, S. S. (1962): *Affect/Imagery/Consciousness, Vol. 1: The Positive Affects*; (1963): *Vol. 2: The Negative Affects*. New York: Springer.

[3] Lewis, H. B. (1971): *Shame and Guilt in Neurosis*. New York: Int. Univ. Press; (1986): Resistance: a misnomer for shame and guilt. In *Techniques of Working with Resistance*, ed. D. S. Milman & G. D. Goldman. Northvale, NJ/London: Aronson.

[4] Wurmser, L. (1981): *The Mask of Shame*. Baltimore: Johns Hopkins Univ. Press.

[5] Stern, D. N. (1985): *The Interpersonal World of the Infant. A View from Psychoanalysis and Developmental Psychology*. New York: Basic Books.

affective display and generation in infant-caregiver affective communication, which is established preverbally. Here I wish he had been specific rather than allusive about the role of the other senses: hearing and the tactile and kinesthetic functions of the neonate's whole body interacting with the caregiver's feeling, handling, speech, and song. This is the context in which visual acuity, poor at birth, begins its rapid development. Nathanson, for his second edition, should consider the case of the congenitally blind and the congenitally deaf infant. In each case, with good mothering and expert help, the child may develop normal affective and cognitive functions. Biology, fortunately, has provided a redundancy of sensory equipment.

Nathanson is ambivalent about psychoanalytic theory. At several points he is ready to discard drive theory or the structural theory *in toto*; at other points he is more conciliatory, revealing a good grasp of what is involved in psychoanalytic theory and practice. To his credit, he respects the views of psychoanalysts—e.g., Wurmser—who have no difficulty in integrating the newer data on shame into their analytic work and thinking. Nathanson has difficulty with shame anxiety, tending at times to see shame rather than anxiety where it is obvious that both are present. This problem, I believe, derives from his allergy to drive theory, which has historically focused on anxiety and guilt to the neglect of shame. Nathanson is at his theoretical best in dealing with the relation of shame and guilt to depression.

Leon Wurmser's "Shame: The Veiled Companion of Narcissism" is an important contribution to the topic. It underlines his prior extensive exposition of shame as a recurring major source of resistance in psychoanalysis. Its twenty-eight pages are a model of scholarship, lucidity, and concision. Wurmser clarifies the relevant phenomenology of shame, including its multilayered manifestations, shame as defense, and the defenses against shame. Among the latter he presents bulimia which "serves to 'counter-devour' the 'devouring' looks of others. Such voracity is thus a weapon against shame, yet it becomes in turn a new source for shame—again the endless perspective" (p. 81). He applies his insights to the analysis of a young man and to classical characters in literature, strikingly to Dickens's Mr. Dombey.

Wurmser differentiates his concepts of the self and narcissism

from Kohut's; e.g., ". . . we see how narcissism is simply one aspect of all conflicts and of all growth and development. To trust or not to trust, to be dependent or not, to love or not to love, to insist on one's identity or not, to express sexual longings or not—all possess components of self-valuation. The more primitive these conflicts are, the stronger are their narcissistic components. Of course it is not true that the psychology of narcissism is somehow beyond conflict. The deeper the problems of self-valuation or exaggerated expectations of others, the more archaic are those conflicts—the conflicts about wanting to be and to get, to be admired and to admire, to be loved and recognized as special and as unique—and the more shocking the realization when these expectations are more or less cruelly thwarted" (p. 75).

The late Helen Block Lewis's chapter, "Shame and the Narcissistic Personality," superbly complements Wurmser's. She compares her views on narcissism with Kohut's and Kernberg's; her thinking is much closer to that of the latter. We are given a penetrating differentiation between shame and guilt, and a discussion of their interaction in depression. The following sequence is emphasized: shame → shame rage against the object → guilt → repression of the shame rage, which is turned against the self → depression (and other symptoms). Lewis gives technical suggestions about the treatment of this sequence, stressing the need to postpone content analysis until the patient is helped to accept the painful affects. Lewis was a master of tactful intervention. She illustrates the adverse effects of neglecting shame, such as accusatory interventions or iatrogenic humiliation leading to regression, with symptom aggravation and the patient's rejecting treatment. While most analysts will agree that shame should be given more weight in evaluating resistance, they will not follow Lewis's suggestion, elaborated elsewhere in her 1986 paper, that resistance be considered a misnomer for shame and guilt. The matter merits intensive investigation in the psychoanalytic situation.

Since the publication of his highly original, comprehensive theory of affects in 1962 and 1963, Silvan S. Tomkins has been the predominant stimulator of non-psychoanalytic affect research. His influence has grown, too, among an increasing number of psychoanalysts who regard his work as enriching and widening classical theory and practice. Tomkins has fruitfully extended his thinking

and research into social psychology, e.g., ideology and epistemology. His basic affect theory is grounded on neurophysiology and evolution; his refinement of Darwin's classic presentation of the face and affect display is, per se, an important contribution to biology and psychology.

The editor in effect asked Tomkins to summarize his life's work in relation to shame. The resulting chapter, "Shame," is much too short for the task, but Tomkins has done a fine job of condensation and highlighting. This essay requires rereading for optimal harvesting and for clarification of the psychoanalytic reader's reservations and disagreements. I found most interesting Tomkin's penetrating exposition of the variety and complexity of shame phenomena and, in the last five pages, a fascinating sampling from the history of sexual shame. He describes the differences among the ancient Greek, Roman, and Indian civilizations, and between the Catholic and Puritan attitudes. Also of interest is a vignette from his research on ideology.

Tomkins expresses disagreement with drive theory: the affects come first and the drives are derivatives of the primary affects. I go along with this view, but not with his virtually ignoring the drives as important secondary sources of affect, nor with his implicitly dismissing the significance of the erogenous zones—as though, for example, the rich endowment of superficial and deep receptors in the genitalia do not have commensurately major subcortical and cortical projections for the registration of affect. A more obvious fault resides in Tomkins's view of guilt. In contrast to Lewis and Wurmser, he relegates guilt to a peripheral position as one of the manifestations of shame, using the term *shame as guilt* more frequently than *guilt*. He is inconsistent here, tending to give guilt its due when dealing with a clinical context.

We have a special literary, philosophical, and psychoanalytic treat in Emmett Wilson, Jr.'s chapter, "Shame and the Other: Reflections on the Theme of Shame in French Psychoanalysis." The importance of shame and its cognate states is more widely recognized in the French psychoanalytic literature than in the English. Wilson, familiar with French culture, attributes this chiefly to the French being more solidly grounded in philosophy. He outlines the pertinent philosophical links and concepts, particularly Hegel's and Sartre's influence on psychoanalytic thought. After a section

on Lacan, Wilson discusses the contributions of French psychoanalysts under the following headings: Psychoanalytic Literary Criticism; The Perversions in General; Scoptophilia, Narcissism and Shame; Shame and the Ego Ideal; and Shame, Guilt and Depression. In his conclusions, Wilson stresses the need for the study of shame in the further development of psychoanalytic theory.

Carl D. Schneider is a psychoanalytically knowledgeable pastoral psychotherapist. His chapter, "A Mature Sense of Shame," deals with the development of a normal sense of shame and its operation in the adolescent and adult. His final pages deal with the therapist's sense of shame in handling the patient's shame. Interesting, too, is his discussion of analytic tact in its relation to the history of Freudian theory.

Warren Kinston's "The Shame of Narcissism" is the work of a creative psychoanalytic clinician and theorist. He divides narcissism into *self-narcissism* and *object-narcissism*, which operate in dynamic reciprocity. In the former state, the person has a sense of shame, is capable of intimate relations, and respects the individuality of the other. In the latter, the individual might be capable of successful business and superficial social relations, but not personal intimacy. In the extreme case, the object-narcissist is shameless and apt to behave in a mindless and destructive fashion. Of chief etiologic importance in producing the definitive object-narcissist is a mother who treats the infant as an extension of herself, as a container for her projections. In explicating his views, Kinston reviews psychoanalytic contributions to the study of shame. Freud's longest discourse on shame is in *The Interpretation of Dreams*, where he discusses dreams involving nakedness, shame, and the wish to hide. Among other noteworthy items are Kinston's theoretical views on exhibitionism, shame, and aggression, and the defenses against shame.

Nathanson's "Shaming Systems in Couples, Families, and Institutions," is a clinically astute, detailed account of the interpersonal aspects of shame.

Complementing Nathanson's chapter, Andrew P. Morrison's "The Eye Turned Inward: Shame and the Self," deals precisely with the intrapsychic dimension, with the vulnerability to shame created in the infant by a non-empathic mother. Such an impaired mother cannot provide the mirroring function essential for devel-

opment from infantile grandiosity to object relations. This is the clearest clinical and theoretical account by a self psychologist I have read in recent years. Morrison is also clear about his agreement and disagreement with Kohut.

Robert J. Stoller's "Pornography: Daydreams to Cure Humiliation" is a notable contribution to our understanding of shame in the perversions. He makes a salient distinction between fantasy and daydream. His thesis, that a major function of daydreams is to ward off and then undo the effects of humiliations, is outlined and elaborated in his longer publications. Re shame and humiliation, the latter is deeper and is more likely to elicit some form of retaliatory revengeful aggression. His stand on resistance is essentially the same as Lewis's: "Most resistance, to me, is simply a person's awareness—conscious, preconscious, and unconscious—of fearing feeling humiliated" (p. 305). It is far from that simple, but this concept is worth attention.

Otto Allen Will, Jr., has devoted his productive career chiefly to the treatment of schizophrenic disorder. Despite its brevity, his chapter, "The Sense of Shame in Psychosis: Random Comments on Shame in the Psychotic Experience," sharply outlines many aspects of shame in the patient and the therapist. In theory, he leans heavily on his mentor, Harry Stack Sullivan, and his interpersonal psychiatry.

Joseph H. Berke's "Shame and Envy" has high literary and clinical appeal. He supplies a moral and ethical dimension to his analysis of shame and narcissism by initially focusing on sin. He reduces Chaucer's seven sins to three: envy, greed, and jealousy. He differentiates the three, envy proving to be the most destructive: "We live in a world where envy is continually unleashed and collusively denied" (p. 325). The envier fears a shameful exposure of his inferiority, dependency, fragility, and impotence. The defenses against shame parallel those against envy. Important developmental issues pertaining to shame and narcissistic vulnerability are delineated.

The volume concludes with a strong chapter by Melvin B. Lansky, "Shame and Domestic Violence," an area in which he has eminent expertise. He illustrates his theoretical orientation with a most instructive case presentation, detailed excerpts from the first four sessions in the treatment of a couple. This is a masterly psy-

choanalytic demonstration of how individual psychopathology in the spouses produces a malignant relationship. Lansky underlines aggression released by humiliation, shame, and rage as a source of domestic violence.

For the second edition of this book I recommend the editor consider the following topics: (1) shame in psychoanalysis and psychotherapy with children and adolescents; and (2) shame in the treatment of those with sensory and/or motor handicaps, congenital and adventitious.

H. ROBERT BLANK (WHITE PLAINS, NY)

THE ROLE OF PSYCHOANALYSIS IN PSYCHIATRIC EDUCATION: PAST, PRESENT, AND FUTURE. Emotions and Behavior Monograph 7. Edited by Sidney H. Weissman, M.D. and Robert J. Thurnblad, M.D. Madison, CT: International Universities Press, Inc., 1987. 349 pp.

In recent years psychoanalytic organizations in the United States have had to grapple with essential issues pertaining to the education and participation of the non-medical members of our discipline. This activity has had many dimensions, some constructive and some malignant. One general point of reference has focused on the traditional alliance between organized psychoanalysis and medicine-psychiatry, but relatively little has actually appeared in the recent psychoanalytic literature concerning this supposedly strong connection, save for isolated contributions here and there dealing with the problematic relationship between psychoanalysis and academic psychiatry. More specifically, the analytic literature has had little to offer in any integrated fashion about matters pertaining to the education of psychiatric residents. This is all the more surprising since it is precisely the psychiatric residency program and the contribution of psychiatry to general medical education which in the past have insured an ongoing supply of medical candidates for the psychoanalytic institutes. That there is an unsettling crisis in the guarantee of this supply at this point is news to no one. Hence, this seventh monograph of the Emotions and Behavior Series from the Chicago Institute is very timely.

The volume advertises its contents as "far-ranging"; and indeed a wide variety of topics is addressed, ranging from assessment of

residents' attitudes about obtaining treatment for themselves during psychiatric training to the allegedly central importance of certain points of view (self psychology, one brand of the "developmental model," etc.) as organizing principles for the psychiatric curriculum. The thirteen papers are divided into five sections, each of which has an introduction by the editors, outlining the major points of each paper in an attempt to integrate them. The five sections involve a history and overview, psychoanalytic models, applications of psychoanalysis in general psychiatry, the teaching of psychoanalytic concepts, the resident's perspective, and some thoughts for the future. It would seem from the headings that this collection addresses a variety of essential topics for psychoanalytic educators to ponder. To brandish an old saw, there may be something for everyone here. But, the end result is occasionally less successful than the menu appears to promise, largely because of the varying quality and relevance of the essays. Several are challenging and thought-provoking, while others seem merely self-serving or poorly conceptualized.

The book starts out well with two straightforward pieces. The first by David Hawkins gives a useful overview of the history of psychoanalysis in American psychiatry and the changes that have been occurring in the latter which have reduced the position of psychoanalysis in psychiatry from one of dominance to one of competition with other important paradigms. This is followed by Robert Michels's lucid view of the current place of psychoanalysis in psychiatric education. He feels that analysis offers several unique ingredients to the student's learning and experience in psychiatry, and that the latter would be a dull and vitiated discipline without this enriching psychological component. However, Michels also adduces several reasons for removing the teaching of psychoanalytic psychotherapy from the core content of psychiatric training. He identifies in clear fashion some common problems in the average resident's psychotherapy experience, but then arrives at this illogical conclusion, which seems to overlook the common sense inherent in most attempts to work within the constraints of the current system.

The second section on psychoanalytic models is the weakest and least interesting in the book. Both papers in this part serve essentially as advertisements for a given point of view promulgated as

necessary for any resident psychotherapist's work. Donald Schwartz describes a "developmental" and quasi-genetic perspective on clinical material that would seem to be introducing something new. However, neither the theoretical statements nor the clinical material convinced this reader that this particular developmental emphasis is different from what most analysts would offer and have been offering all along. Hyman Muslin then provides a kind of summary primer on self psychology that reads nicely enough for what it is. But what is the purpose of this type of paper in this volume? These efforts take on a kind of self-justifying tone. If the idea were to give a democratic representation of present-day currents in the psychoanalytic arena, then why have statements not been included from other "schools"—such as the object relations groups, the interpersonal groups, etc.? Particularly striking is a persistent undertone in the collection, and a blatant one in this section, that de-emphasizes the Freudian psychoanalytic principles that most analysts adhere to.

This last criticism is pertinent to the first of the two papers comprising the next section, one by Michael Franz Basch on teaching the distinctions between psychotherapy and psychoanalysis. Basch dilates here on his own critique of classical metapsychology and on alternative models which he feels would inform psychoanalytic psychotherapy more usefully. This theoretician, like several others in the book, makes an important point: doing clinical psychoanalysis and doing psychotherapy are not exactly the same thing, and that fact should be represented in how each is taught and supervised. However, the chapter stands or falls in this regard, depending upon one's responsiveness to Basch's particular brand of theory-making. (This reviewer finds a largely misappropriated metapsychology used as a pretext for Basch's wish to revamp psychoanalytic thinking.) I am not suggesting that his ideas should not have an airing, but I have questions about his main agenda here.

In contrast, the next paper, by Philip Muskin and Donald Kornfeld, is a succinct, unassuming, convincing demonstration of the importance of the teaching of psychoanalytic principles for work in consultation-liaison psychiatry, exemplary of what analysts can offer in a general psychiatric and medical setting. They provide, first, a nicely organized overview of the types of patients generally seen and the typical problems that each presents. This is followed

by several sections outlining some specific features of this kind of work, which can only be handled adequately with psychodynamic understanding. Several case examples are then used to demonstrate that in this most medical and biological of settings, psychoanalytic theory plays an indispensable role in the general consulting psychiatrist's capacity to function effectively.

The subsequent section, on teaching psychoanalytic concepts, is the largest in the book. It deals with a spectrum of issues, including what the contents of a core curriculum should be for residents, how to integrate different theoretical and clinical perspectives, and the importance of taking into consideration certain difficulties for the resident subjected to competing paradigms and/or to so-called eclectic approaches. Three of the five papers in this section are particularly interesting in connection with these issues.

Jeffrey Andresen's discussion of the specific factors peculiar to the teaching and learning of psychodynamic data, which are not complementary to the teaching and learning of biological data, is particularly noteworthy. His carefully reasoned deliberations focus on the effects of the resident's own emotional and developmental needs on learning psychodynamic principles, as well as the effects of the changing socioeconomic environment that impinges on these internal factors. Beyond the resident's contributions to the situation are those of the teachers. Andresen takes seriously that those who do the teaching are not necessarily educators in their skill or their primary occupation, as well as that those who are the latter often may not have an adequate breadth or depth in the type of clinical experience that is so crucial to the development of confidence and conviction about psychodynamic principles. Andresen's treatment of these and other issues is sensitive and challenging in the most constructive sense.

Thurnblad, writing about the problems of the resident confronted with an eclectic approach, takes up some similar considerations in a thoughtful paper. His slant here, while addressing the problems of match between patient, resident, supervisor, and theory, is to point toward the need for a unified theory. Weissman concerns himself with some interesting and not usually considered questions about the appropriateness and timing of personal analysis both for residents intending to enter formal analytic training and for those who will not.

Another very interesting contribution, by Weissman and Philip Bashook, reports on the findings of a 1982-1983 questionnaire survey of PGY-1 residents before, during, and after their initial year of training. They attempted to elicit residents' views on several topics, including their definitions of key psychiatric concepts, their perceptions of the philosophy of their respective programs, the skills they rated as most important in the practice of psychiatry, their feelings about undergoing personal treatment during the residency, and correlations among the subgroups of those who intended to go on to psychoanalytic training versus those who did not. A number of interesting findings have come from the study, too many to report on here. But the data raise some curious questions. The majority of residents view learning psychotherapy as the most important skill to be acquired in their training. Yet, apart from the residents who state an intention to pursue psychoanalytic training, few feel that personal treatment plays a significant role in their development as therapists. It also appears that the majority of residents who intend to obtain analytic training have made the decision before entering the residency program (the data suggest that about 20% of residents beginning psychiatric training indicate an interest in analytic training, although not all of them go on to matriculate). Suffice it to say that this paper presents some crucial information from residents themselves, which deserves study, as it can help inform analysts more accurately about those they are trying to reach.

Many of the issues raised by the various authors in this collection are integral to the task of educating future psychiatrists, including those who will become analysts. The major problem with these essays remains the lack of clarity about who the readership is imagined to be. Some of the papers seems to be aimed at beginning residents themselves, while others are on a fairly sophisticated level intended for academic psychiatrists. Most of the contributions read easily, however, and one can give a justified closer look at the several that deserve more serious, careful, and immediate attention. It is important to do so, lest psychoanalysis lose its influence in medical and psychiatric training.

ERIK GANN (NEW YORK)

WHO AM I THIS TIME? UNCOVERING THE FICTIVE PERSONALITY. By Jay Martin. New York/London: W. W. Norton & Co., 1988. 255 pp.

Jay Martin's book opens with these words: "When I was seventeen years old, my aim in life was to become a poet." In a sense, Martin has achieved this aim, for he has not only become a sensitive poet of the psyche, he also writes with poetic beauty.

He approaches the "fictive personality" as a psychoanalytic poet, stressing first the universality of the fictive elements in everybody's character structure: "It is a central fact of human life that each person invents a reality in which to live. We do not discover reality, we construct it" (p. 26). Martin then takes into consideraton the cultural potential of personal fictions: "The profusion of fictions is central to creativity" (p. 13). Finally, he refers to their "darker side," that is, their pathological dimension: "The fictive personality originates when the self or the world seems inauthentic, fragmentary, or unavailable, so that only ready-made fictions seem whole or complete" (p. 28). The major part of this work is devoted to exploring these three aspects of the fictive personality.

Martin then demonstrates the way in which the pathologically fictive personality is built up from childhood onward, beginning with the unconscious problems of parents. He demonstrates convincingly that when parents fail in their task of helping their children construct a reality sense, a "vacuum of attachment" may result and children must then invent their own personalities. As children develop, social influences also come to play an important role: the fictive personality will use novels, plays, television, and social myths to fill this vacuum.

Through his clinical observations Martin came to feel that one of the central therapeutic tasks with such patients is to "build up a kind of archaeology of the self, excavating layer after layer of older narrative lives" (p. 30).

From there on, the author provides fascinating clinical insight into these pathological character organizations, ranging from John Lennon's murderer to celebrated assassins such as John Wilkes Booth, who so carefully planned the killing of Abraham Lincoln. As Martin puts it, for Booth, "assassination was performance."

His investigation leads him from these make-believe actors, "actors in the theater of the real," to exploring the relation between modern acting theory, real actors, and fictive personality structure. A penetrating chapter is devoted to this latter theme.

The illustrations of these major themes move with grace from the study of Don Quixote, through the moving clinical examples of analytic patients, "Terry," "Melissa," "Arthur," and "Thomas," to a consideration of fictional characters such as those made famous in Woody Allen's *Zelig* and *The Purple Rose of Cairo*. These are then followed, among other illustrations, by studies of the lives of Jean-Paul Sartre and General Patton, "who saved themselves from hopeless depletion and dependency through the creative use of fictions" (p. 76). The statement that all these different personalities "used fiction to explore, and in some manner to solve, problems of identity" (p. 106) sums up one of Jay Martin's basic theoretical positions.

However, it is the author's opinion that perturbation of this order defies clinical categorization. He addresses this question in the following manner: "Is it a disorder of thought? A deficiency of the self? An emotional disturbance? Does it signify neurosis? Borderline disorder? Psychosis? Is it a compulsion? A choice? Where is its origin—in early disorder and childhood sorrow? In trauma? In the preoedipal stage? . . . Diagnoses do not help understanding here . . ." (pp. 124-125). Then, using his rich clinical and historical examples, Martin goes on to show that some patients would fall into the category of having schizoid disorders, others into that of having major depressive states, and still others would be considered to suffer from systematized delusions or narcissistic defects.

The author sums up his own position in stating that the "fictive personality arises when there is a simultaneous disturbance of both normal narcissism and relations to others" (p. 138). Taking as his standpoint that "relatedness is based on the first connections that the child has with parents and family," his reflection leads him to posit that when early relations have not gone smoothly, but instead have repeatedly brought in their wake physical, mental, and emotional injuries, these "can drive the child away from associations, locking the self inside itself" (p. 133).

This comprehensive study encompasses an examination of the findings of other research workers, including consideration of

Guntrip's study of the "schizoid personality," Winnicott's concept of the "false self," and Deutsch's "as if" personality, and it reviews the work of Anna Freud and Ernst Kris in this field. An insightful chapter also deals with Freud's "fictions," their effect upon his theory building, and the extent to which *The Interpretation of Dreams* might be considered "an autobiography of Freud's inner life."

This thought-provoking and beautifully written book concludes with the following words: "It is neither possible nor desirable to dispense with fictions. But to possess *only* fictions means to be possessed by them. However many roles we play for others, we must play as few as possible for ourselves."

JOYCE MC DOUGALL (PARIS)

THE BORDERLINE PATIENT. EMERGING CONCEPTS IN DIAGNOSIS, PSYCHODYNAMICS, AND TREATMENT. VOLUMES 1 & 2. Edited by James S. Grotstein, Marion F. Solomon, and Joan A. Lang. Hillsdale, NJ: The Analytic Press, 1987. 444 pp., 330 pp.

This ambitious two-volume compendium contains thirty-six chapters written by some of the outstanding contributors to the literature on the borderline patient. The authors represent a diverse spectrum of opinion. They include individuals who are widely published and well known: L. Bryce Boyer, Peter L. Giovacchini, James Grotstein, Otto Kernberg, Joseph Lichtenberg, Jerome Oremland, Harold Searles, James Masterson, William Meissner, Mortimer Ostow, Michael Stone, Marian Tolpin, Robert Stolorow, Vamik Volkan, etc. The chapters cover diagnosis, psychodynamic and developmental formulations, biological and genetic formulations, psychoanalysis and psychoanalytic psychotherapy, and, finally, alternative approaches to treatment. There are comprehensive references at the end of each essay, as well as excellent subject and author indexes at the end of each volume. There are also orienting introductions to each part by the editors.

Michael Stone and John Gunderson employ empirical psychiatric research data to approach the diagnosis from multiple perspectives: Stone defines various aspects of the borderline diagnosis: (a) an area of functioning and personality organization; (b) a syndrome based on observable phenomenology; (c) a spectrum of

disorders borderline to the schizophrenic and affective disorders; (d) a spectrum of self disorders; and (e) a distinct personality type in its own right. David Terman sees borderline disorders as characterized by a deficit of selfobject functions. He feels that they differ from the narcissistic personality disorders quantitatively rather than qualitatively. William Meissner reiterates his oft-published belief that the borderline disorder is a loose variety of entities covering a spectrum from lower to higher order pathology, with two major configurations, hysterical and schizoid.

Gunderson cites the specific characteristics of the borderline personality disorder as (1) low achievement; (2) compulsivity; (3) manipulative suicide attempts; (4) heightened affectivity; (5) mild psychotic experiences; (6) high socialization; and (7) disturbed close relationships. He describes three levels of functioning. The first occurs when a primary object is present and supportive; one finds depressive, masochistic, bored, lonely features predominating. At level two the primary object is frustrating and the possibility of loss is raised; angry, devaluative and manipulative features predominate as efforts are made to control or to coerce the object to stay. Level three ensues when a borderline person feels the absence of a primary object. At that level, there are brief psychotic episodes, panic states, or impulsive efforts to avoid panic. Meissner elaborates his concept of a spectrum by noting that reality testing is more central in diagnosing forms of pathology closer to the psychoses and less important in discriminating higher order borderline conditions.

Winnicott's influence on Peter Giovacchini is quite evident. From analyses of mothers and children, he concludes that the mothers of borderlines used their children as transitional objects and that the children's emotional development became fixated in the "in between transitional space, leading to specific types of character structure and ego defects which, when occurring in the middle layers of the psychic apparatus, manifest themselves as defective modulating elements" (Vol. 1, p. 203). These patients, according to Giovacchini, display a kind of fragmentation or splitting, in which connecting bridges between higher and lower levels are missing. The mother of the borderline patient is depicted as low-keyed and lacking in responsive animation. Giovacchini concludes that these patients require a mode of relating that is dif-

ferent from analytic neutrality. Therapists need to demonstrate their concern in order to promote the patients' developing autonomy. Giovacchini emphasizes the need for construction of a holding environment appropriate for this particular group of patients. "Being with the patient means surviving his rage and not attacking or rejecting him as happened in the infantile environment. It is more of a warm glow in which the patient feels comfortably held, which is a necessary precondition for the underlying traumatic conflicts to emerge and for the acquisition of psychic structure" (Vol. 1, p. 202).

Masterson sees the crucial psychopathology in the borderline as abandonment/depression. There are pathological ego alliances which are ego-syntonic, since they make the patient feel good and enable maladaptive aspects to be denied. The therapist must render the functioning of these alliances ego alien by confronting the denied maladaptive aspect. The goal of treatment is to work through the abandonment/depression to free the patient to resume development toward whole object relations. It is based on the postulation that the borderline maternal object rewards clinging and withdraws from the child or behaves negatively or aggressively toward the child's efforts at separation-individuation. Certainly, this is a constellation observed in many borderlines, but it is questionable whether it is ubiquitous or is central to all borderline pathology.

Marian Tolpin sees the splintered sexuality and aggression of the borderline as emanating from a faulty underlying self organization. The endopsychic faults derive from failures in the multiple functions of childhood "self-objects." These failures lead to a chronically "split-up baby" rather than a "cohesive baby." Drivenness is seen as part of a compulsive effort to compensate for missing psychological functions. Self-object functions seem to have failed to undergo adequate internalization. "An analytic cure would consist of acquiring the needed functions from the therapist as a new edition of earlier self-objects and of 'transmuting' these functions into the patient's own psychological substance" (p. 247). Transmuting is defined as organizing, integrating, and synthesizing. The therapist endeavors to re-establish a latter-day transference edition of a self-object unit "which can lead to self-development with a new and different ending" (p. 248). Repeated experi-

ences of understanding the shattered cohesion lead to the systematic working through and internalization of the new self-object functions, which enhance psychic structure. This structure enables the patient to "maintain and restore himself."

James Grotstein emphasizes somatopsychic and psychosomatic afflictions of the central nervous system as being relevant to borderline pathology, within the concept of disorders of self-regulation. He views classical psychoanalysis as being too mentalistic to account for all the disorders of the borderline syndrome, while overemphasis on the biological cannot deal with the patient's *experiences* of the defects, past or present. The defects are seen to have emerged as defenses against biochemical imbalances which then become chronic and take on the autonomous psychological quality of resistance which can only be dealt with through psychological treatment. An interdisciplinary context for the treatment of the borderline as having a disorder of self-regulation is advocated. Disorders of self-regulation lead to primary failures in the achievement of self-esteem, psychic safety, and interpersonal trust. The symptoms of the borderline disorder are seen as constituting secondary attempts to regulate distress and disruption imposed by the primary failures.

The general themes in the discussions of borderline pathology include the role of neurobiological factors, the relationship to affective disorders, and the relevance of schizotypal and schizophrenic spectrum disorders. There is consensus that the borderline has difficulty in maintaining object relationships and in regulating self-functions. Their stable instability, polyneurotic qualities, vulnerability to regression, and partial disorganization are generally recognized. There is a strong element of agreement about their difficulty in empathizing with others, who may be used as transitional objects, self-objects, autistic objects, symbiotic objects, or parasitic objects. The editors observe that the borderline patient experiences enormous difficulty in dealing with others, yet their yearning for relationships remains alive.

The section on treatment is prefaced by the editors' emphasis on how borderline patients can disturb and challenge us as therapists, with their demanding, perplexing, bewildering, stormy qualities. Transferences and countertransferences can be primitive, intense, and disturbing. "The phenomena encountered in treating these

people is usually experienced as fleeting, changeable, and hard to classify" (Vol. 2, p. xv).

Vamik Volkan outlines sequential stages in the treatment of borderlines: establishment of a reality base, setting of limits, and, later, use of the couch and exclusive use of interpretations. Volkan emphasizes the necessity of preparation for eventual intensive, undiluted psychoanalytic psychotherapy. His discrete six phases would probably be judged too formulaic to be of universal applicability. They may be more applicable to the more primitively organized patients in the spectrum.

Harold Searles emphasizes the intensity of countertransference phenomena and the importance of symbiotic relatedness in treating borderline patients. It is "necessary for the therapist to lead the way in developing an internalized image of the patient before the latter, partly by identification with the therapist, can do similarly" (Vol. 2, p. 38). "Difficulties are referable to the patient's reprojecting his own introjects and other unconscious contents with great intensity into the therapist" (Vol. 2, p. 38). The therapist then finds him/herself in strange, subjectively non-human transference roles. The patient's defensive splitting complicates the disturbing transference even further. The consequence is that the therapist, in unconscious flight from one of these transference roles to another, tends to interpret them prematurely to the patient or retreats from the interpretive role.

Bryce Boyer is acknowledged by the editors to have a particularly strong, intuitive understanding of primary process mechanisms in the associations of borderline patients. Boyer sees these patients as having sought out aspects of themselves in tentative objective attachments. According to him, they use primitive defenses, especially introjective and projective mechanisms and splitting, as well as more mature defense mechanisms. "Therapeutic success is achieved by replacing immature ego and superego functions with less archaic and self-punitive ones. The therapist provides a milieu in which regression to and reliving of the periods of original trauma can take place and be understood and rectified through interpretation and developing object relations" (Vol. 2, p. 54).

Peter Giovacchini cautions that the therapist is drawn into a psychotic transference situation that seems absolute and concrete. The patient seems to be beyond understanding, producing illusions or

distortions, and resists the analyst's attempts at interpretation. Giovacchini again follows Winnicott in describing many borderline patients as being victims of privation as opposed to deprivation, emphasizing ego defects. "Privation" is defined as an early ego state which evolves in an individual who has experienced very little gratification of basic needs, so there are few memory traces of gratifying experiences. The "deprived" patient in contrast has known some gratification. If the patient cannot distinguish the analytic setting from the infantile ambiance, the therapist is faced with a psychotic transference. The patient reacts to the transference relationship via infantile defenses and adaptations, and tends to create an ambiance that will support these defenses. To the extent that the infantile environment was unreasonable and unpredictable, the patient repeats this constellation in the transference. Thus, borderline patients often tax the therapist's tolerance as they "vociferously claim their right to be unreasonable."

Otto Kernberg provides a chapter on managing suicidal potential in borderline patients. Of critical importance is the clinical severity of the depression, if a major affective component is superimposed on the borderline personality disorder. Tendencies toward self-mutilating behavior and "suicide as a way of life" are not uncommon. Kernberg emphasizes the therapist's need to honestly accept the possibility of failure with a patient who presents with malignant narcissism and a severe suicidal potential. There is a need to explore and resolve the patient's unconscious fantasy that the therapist wants the patient to stay alive, which gives the patient power over the therapist. The therapist must be able to empathize with the patient's suicidal temptations, longing for peace and excitement, self-directed aggression, and pleasure in wreaking revenge against others, as well as with the escape from guilt and the sense of power contained in suicidal expressions. These issues must be openly explored in the treatment. One must acknowledge that "we cannot help all of these patients and some are better helped by some of our colleagues and some cannot be helped at all with the state of our knowledge" (Vol. 2, p. 79).

Jerome Oremland's contribution involves the use of dreams with borderline patients. Dreams aid him to gauge significant shifts in regression and progression, as he illustrates with generous clinical vignettes. Oremland contends that the study of transference in

borderline personality and schizophrenia enables us to explore and define the way in which the self is actualized in relation to others. He presents clinical vignettes of borderline-psychotic disturbances of self- and object representations as they are symbolized in dreams.

Bernard Brandchaft and Robert Stolorow, using a self psychology point of view, employ the concept of "intersubjectivity" in their treatment of borderline patients. They see developmental failure as being recapitulated in the transference. The therapist's failure to be attuned to the patient's experiences recapitulates the original psychopathogenesis. The patient's manifest psychopathology is co-determined by the patient's self-disorder and the therapist's ability or inability to understand it. The therapeutic task is to analyze experiences of self-object failure which are revivals in the transference of the patient's early history of developmental deprivation and interference. Therapists will inevitably fail the patient, they assert, causing borderline symptoms to appear. When the subjective validity and meaning for the patient of such disjunctions and self-object failures are unanalyzed or are chronically unrecognized, a therapeutic bond is not established, and borderline phenomena become fixed as "borderline personality organization." Again, I am inclined to view this formulation as being much too narrow, avoiding as it does neurobiological contributions, conflicts, and drive-defense constellations. Emphasis on empathy is certainly wise, but it does not comprehensively attend to the therapeutic challenge.

Joseph Lichtenberg's perspective also evolves from a self psychology point of view. His central thesis is that in both narcissistic and borderline personality disorders the patient has a disturbance in the experience of the emergence of the self as a cohesive, integrated whole. Lichtenberg asserts that analysts must utilize a mode of perception in which they are, as systematically as possible, positioning their listening from "within" the patient's state of mind. He indicates that this enables the analyst to contact the patient's experiencing of him/herself as, for instance, having active choices, feeling entrapped, or feeling overwhelmed into passive surrender. I am once more compelled to question whether empathy is enough, without a clear understanding of the various contributions to the patient's psychopathology and dysfunctional experience.

The editors observe that it is "these patients' propensity to establish transference characterized by transitional modes of relatedness and evoking profound countertransference or so-called projective counteridentification in the therapist" (Vol. 2, p. 301). That is, "therapists who treat borderlines become patients themselves or at least deeply involved emotionally to a point where their analytic stance is threatened" (Vol. 2, p. 301). As contrasted with neurotic patients, limitations are imposed on borderline patients by their fear of progress and their negative therapeutic reactions, as well as by fears of disappointment and retaliation. These concerns are voiced by many of the authors, although there is agreement that psychoanalysis or psychoanalytic psychotherapy can be of benefit for many borderline patients. The editors observe that self psychology, because of its emphasis on empathic observation and self-object deficits, offers a self-sustaining function for such patients.

A number of the contributors see the borderline as being in transition from infantile to mature forms of dependency. Many comment on the phenomenon of hypersensitivity to life experience as a central feature of the borderline condition. Some express concern that borderlines may have difficulty emerging from primary narcissism because of deficient experiences of primary attachment and bonding. Borderlines have difficulty making friends because they have difficulty accepting separateness or individualness. Since they cannot mourn the absence of their primary objects, they cannot achieve object constancy.

These two volumes provide a spectrum of opinion relating to diagnostic, psychodynamic, and psychotherapeutic approaches toward understanding the borderline patient. At times the editors raise controversial questions about the divergent points of view. It is my impression that the classical psychoanalytic approach has been given short shrift relative to the emphases on object relations theory and self psychology. I might have been interested in the inclusion of a section by Abend, Porder, and Willick, for example.

Nevertheless, this work provides an opportunity to those who are involved in working with borderline patients to familiarize themselves in depth with the ideas of the various authors, all of whom contribute to our understanding of the syndrome. No new ground is broken, but the book provides a useful concentration of material by influential contributors.

WARREN H. GOODMAN (GREAT NECK, NY)

CHILDHOOD BEREAVEMENT AND ITS AFTERMATH. Emotions and Behavior Monograph 8. Edited by Sol Altschul, M.D., with Foreword by George H. Pollock, M.D. Madison, CT: International Universities Press, Inc., 1988. 459 pp.

How do children experience the loss of a loved one? Do they mourn as adults do? The literature on childhood reactions to death contains much disagreement. Authors such as Wolfenstein[1] believe that children have what she called a "developmental unreadiness" for mourning prior to adolescence; i.e., they cannot mourn until they give up their first incestuous objects. Others, such as Anna Freud,[2] hesitate to apply the term *mourning* to the bereavement reactions of very young children until there is a certain capacity for reality testing and object constancy; certainly this develops well before adolescence. Most authors acknowledge that children do react profoundly to death, particularly to those closest to them, such as a parent, but that their reactions may differ substantially from those of the adults around them. Such is the belief of the authors included in this collection of papers edited by Sol Altschul. It is a welcome addition to the literature.

In his introduction, Altschul notes that the original interest in how children cope with mourning the death of a parent grew out of the work of Joan Fleming, who, in the 1950's, became interested in adult analytic patients who had themselves suffered the death of a parent in their formative years. What Fleming found out was that these patients often denied the significance of the loss; they thus avoided the mourning process, which in turn led to an incomplete mourning and an arrest in ego development.

In 1976, the Barr-Harris Center for the Study of Separation and Loss during Childhood was set up under the auspices of the Chicago Institute for Psychoanalysis. Since its inception, the Center has provided services to over three hundred children, ranging in age from two to ten years, who lost a parent by death in the previous two-year period. It is to be noted that the children and their families were seen for evaluation and/or psychotherapy and not for psychoanalysis.

[1] Wolfenstein, M. (1966): How is mourning possible? *Psychoanal. Study Child*, 21:93-123.

[2] Freud, A. (1960): Discussion of Dr. John Bowlby's paper. *Psychoanal. Study Child*, 15:53-62.

Childhood Bereavement and Its Aftermath is, in part, a presentation of work done at the Center. But the book, which is divided into five sections, has a considerably wider scope.

In the first section, Altschul presents a general discussion of the psychoanalytic view of trauma. He prefers Freud's[3] earliest (1893) view that trauma is any experience that calls up distressing affects, such as fright, pain, anxiety, or shame. Whether something is traumatic is determined by how it is processed internally, i.e., one must know the meaning of the experience for the individual.

The second section discusses the Barr-Harris experience directly. The chapter by Arnold Samuels, "Parental Death in Childhood," is particularly good. The author notes that the majority (two thirds) of families come to the Center within the first six months after the death. About 85% of the children seen are symptomatic, with such complaints as sleep disturbances and nightmares. Particularly traumatic are deaths due to murder or suicide; in those cases, no child is able to mourn without intervention. Samuels makes the point that the availability of an adult to support and facilitate bereavement is of great consequence in the ability, in general, of a child to cope with mourning. This point is reiterated in the excellent chapter by Colin Webber, "Diagnostic Intervention with Children at Risk," in Section III (The Barr-Harris Experience —Intervention). Webber further notes that the children's ability to mourn depends upon their developmental level and their previous life experiences, as well as on the degree of availability of the surviving parent. One must remember that the loss of a parent for a child is often a double loss—the child loses one parent to death and the other to mourning.

The chapter by Nan Knight-Birnbaum, "Therapeutic Work with Bereaved Parents," stresses the importance of children's participating in the funeral and religious rites of the family. This is further delineated in the excellent chapter by Benjamin Garber, "Some Transference-Countertransference Issues in the Treatment of Parent Loss." Garber, for example, questions why the surviving parent or family members withhold clarifying information from

[3] Breuer, J. & Freud, S. (1893): On the psychical mechanism of hysterical phenomena: preliminary communication. *S.E.*, 2.

the child. The family members often say they are trying to protect the child when, in fact, they may be more likely trying to protect themselves, so that they inadvertently interfere with the child's mourning process. One very interesting point involves a striking experience noted at the Center: for the first two years at the Center, children were not asked directly about the loss unless they brought it up spontaneously. The result was that the entire evaluation might have been completed without any discussion of the loss. Garber related this oversight, in part, to the therapists' own countertransference reactions to children suffering loss. One might take this experience to heart more generally and think how often children present for evaluation of other traumatic events (e.g., sexual abuse, divorce, etc.) without a thorough exploration of the child's feelings when the child fails to bring up the topic spontaneously.

Another interesting chapter is the one by Karita Miraglia Hummer, "Termination and Endings." She underscores the importance of a genuine termination, whenever possible, with children who have experienced parental loss due to death. Hummer notes that premature terminations due to intervention by insensitive surviving parents whose own needs come first or to changes in life situations leave the child with a second painful loss and the potential for regression or arrest.

Section IV of the book deals with developmental issues. Garber's chapter tells of seven-year-old Steve, who lost his mother suddenly in a car accident. The case material very movingly shows how therapist and patient had to reconstruct a history of the crucial events surrounding the death. Together, the therapist and patient read the poem, "The Missing Piece," in the last sessions, which metaphorically represented for this child the missing sense of his own history.

Section V details the parent loss project, originally under the aegis of Joan Fleming, to whom the volume is dedicated. The Fleming and Altschul chapter, which is excellent, is reprinted from 1963. It demonstrates how psychoanalytic treatment can activate mourning and facilitate resumption of arrested development in adult patients who have suffered loss during childhood.

One of the most fascinating chapters is a psychoanalytic exploration of the famed German sculptor and graphic artist, Käthe Kollwitz. This chapter, by George H. Pollock, was originally published

in 1982. It depicts how early sibling loss and her mother's subsequent depression had a profound effect on Kollwitz's art. These early losses compounded the later loss of Kollwitz's own son.

In the final section, Altschul summarizes the intent of the volume, namely, to contribute to and enlarge upon knowledge in the field, as well as to consider preventive measures when necessary to facilitate the mourning process and subsequent growth. Altschul notes that there is no question that the children seen at the Center experienced profound reactions to parental loss and that some children do go through a mourning reaction as seen more typically in adults.

The book has its limitations. It is neither a statistical compilation of data nor an in-depth study of children who have experienced loss undergoing psychoanalytic treatment. Other books, such as *A Child's Parent Dies* by Furman,[4] more specifically present psychoanalytic case material. Another drawback is the fact that several of the chapters (some of the best) have been printed elsewhere. Nevertheless, the book is quite readable, with interesting new case material of its own. It emphasizes both the effects of parental loss *in statu nascendi* as well as its aftermath as seen in adults many years after the initial loss.

Parental loss by death, incidentally, is more common than one might believe. An estimated 5% of children in the United States lose one or both parents by the time they are fifteen years old.[5] When one considers deaths due to the drug epidemic and the spread of AIDS, as well as the fact that couples seem to be having children at older ages, one can expect this percentage to rise in future years. Because of this, the book may have a wider appeal than originally thought. I would recommend it to those who treat children as well as to those who treat adults who have themselves experienced early loss. Though parental loss due to death is significantly different from parental loss due to other situations, such as divorce or separation, a point made emphatically by Furman, I would suggest that some of the same principles do apply; those

[4] Furman, E. (1974): *A Child's Parent Dies. Studies in Childhood Bereavement*. New Haven/London: Yale Univ. Press.

[5] Osterweiss, M., Solomon, F. & Green, M., Editors (1984): *Bereavement: Reactions, Consequences and Care*. Washington, DC: National Academy Press.

dealing with the vast numbers of children so affected might also benefit from *Childhood Bereavement and Its Aftermath*.

SYLVIA R. KARASU (NEW YORK)

ATTITUDES OF ENTITLEMENT. THEORETICAL AND CLINICAL ISSUES. The Virginia Psychoanalytic Society Book Series: 1. Edited by Vamik D. Volkan and Terry C. Rodgers. Charlottesville: University of Virginia Press, 1988. 106 pp.

This is a series of essays in memory of George Kriegman, the first psychoanalyst to practice in the Commonwealth of Virginia and a founding member of the Virginia Psychoanalytic Society. It takes its theme from his posthumously published paper, "Entitlement Attitudes: Psychological and Therapeutic Implications," which also forms the first chapter of this book.

Kriegman thought of disorders of entitlement as those in which concerns about human dignity, social status, respect, or economic benefits appear paramount. Horney first used the term to describe neurotic patients, such as Freud's exceptions, who expected to be treated in a special manner. Contemporary psychoanalysts tend to think of this as an aspect of pathological narcissism. Kriegman attempted to solve the riddle of whether socioeconomic or intrapsychic trauma plays the salient etiologic role in these conditions by examining evidence gathered in the course of clinical psychoanalytic work. He concluded that the developing individual's relationships within the family, particularly with a mother whose capacity to provide a secure sense of self-worth is defective, are the critical genetic factor in these disturbances.

Two papers draw on psychoanalytic developmental theory. In this category, Maurice Apprey follows the work of Anna Freud in proposing a five-step developmental line "From an Inchoate Sense of Entitlement to a Mature Attitude of Entitlement." It includes: (1) preoedipal sense of entitlement characterized by envy, grandiosity, and self-centeredness; (2) oedipal transformation of aggressive wishes into identifications with admired objects; (3) postoedipal expansion of the concept of social right and responsibilities; (4) adolescent consolidation of a stable sense of self and object that supports the shift from familial to extra-familial ties; and (5) ma-

ture sense of entitlement that allows the young person to give up the discrepancy between expressed entitlement and felt non-entitlement.

Also from child analysis, Robert M. Dorn's "Entitlement: Some Developmental Perspectives" offers two formulations of attitudes of entitlement. One may view them as residua of the tasks of differentiating during the separation-individuation and symbiotic phases. A model based on the theory of transitional objects and transitional phenomena is similarly useful in the clinical management of entitlement transferences in adult patients. According to this model, concepts of reciprocity and fairness originate in family interactions during the nursery school period of development, when they coexist with primitive selfish attitudes. Interference with the toddler's development of these new social attitudes will be reflected in pathological transference experiences of entitlement in adult patients. Dorn offers a convincing illustrative case.

Two contributions from adult analysis present reasoned clinical approaches to patients who suffer from pathological entitlement attitudes. In "Envy, the Most Painful Affect: Its Relation to Entitlement and Helplessness," Cecil C. H. Cullander offers a synthesis of many psychoanalytic theories of envy. He is the only author in this volume to cite Kohut's important work in this area. He also signals the special contribution of women's psychology to the clinical problems posed by envy and entitlement. Not only is envy a painful affect to endure, being envied can also be very painful. The analyst must be able to master the countertransference attitudes incited by a severely regressed, dependent, envious patient who launches profound attacks on the therapist's skill, self-esteem, and well-being. Cullander recommends maintaining a persistent, neutral, interpretive stance. This will, over the long term, he believes, help the patient become able to tolerate the painful affect. He offers a brief case report that convincingly illustrates his approach.

In "The Psychology of Rights," Robert Michels notes that a right is a claim that is justified. A sense of entitlement, whether normative, exaggerated, or inhibited, represents the intrapsychic experience of a right. He discusses the practical aspects of dealing with this central topic in psychotherapy, and offers a rational, commonsense protocol that emphasizes sensitivity and empathy toward the patient's disordered self-regard. Michels suggests that his formula-

tion is especially useful in dealing with patients who enact transference wishes. There is a striking vignette involving a patient who enacts his pathological entitlement in several areas. We do not learn, however, whether the interventions based on this schema were curative.

His work in consultation psychiatry has led Michel Silberfeld to conclude that hope, loss, and entitlement form an indivisible, dynamic triad, In "The Psychology of Hope and the Modification of Entitlement Near the End of Life," he presents the case of a young adult with terminal leukemia. This patient's family could not endure and therefore denied the prospect of a fatal outcome. Their painful recognition that the patient would be denied his right to a normal life expectancy came late and was superseded by despair. Other patients and their relatives come to accept their mortality through a series of gradual, small disillusionments that may be worked through and replaced by realistic hope. This paper represents the interaction of psychoanalysis and psychiatry at its best.

D. Wilfred Abse's "Kriegman's Nonentitlement and Ibsen's *Rosmersholm*" is the most original and important portion of this volume. Abse elaborates on Freud's analysis of the play's central character, Rebecca West, and he goes on to study a group of Ibsen's characters who are afflicted with a sense of non-entitlement that corresponds to the one we observe in psychotic and depressive patients. His sophisticated discussions of entitlement as a superego function and of the development of the ego ideal of parenthood and its fate in cases of involuntary childlessness are outstanding.

The editorial work is superb. Every chapter is clear and coherent; the transition from spoken to written presentation is flawless. This small book, crafted for the most part by quiet clinicians, is a lovely tribute to George Kriegman, another quiet clinician. It is also a reminder of the powerful ways in which psychoanalysis can help very sick people to change themselves and their lives.

SHEILA HAFTER GRAY (WASHINGTON, D.C.)

MICHELANGELO'S SISTINE CEILING. A PSYCHOANALYTIC STUDY OF CREATIVITY. by Jerome D. Oremland, M.D. New York: International Universities Press, Inc., 1989. 322 pp.

Since Freud[1] staked out the territory in his "Moses" paper, analysts have again and again turned to the life and works of Michelangelo

[1] Freud, S. (1914): The Moses of Michelangelo. *S.E.*, 13.

Buonarroti as test cases for their efforts to apply the concepts and methods of psychoanalysis outside the clinic. It is not surprising that they should do so; apart from the appeal of rivalrous identification with the master, the majesty of Michelangelo's work (regarded by many as the pinnacle of Western art), matched by the complexity and the legendary "*terribilita*" of his personality, exerts an irresistible fascination. The Sterbas,[2] Peto,[3] Liebert,[4] and Leites[5] are among those who have yielded to the urge to explore the enigma of creativity through the psychoanalytic study of one or another aspect of its supreme examplar.

Oremland, who in earlier work has touched on other aspects of the study of creativity, joins this company with a major treatise on what has been for almost five hundred years considered Michelangelo's masterpiece—the Ceiling of the Sistine Chapel in the Vatican. It is clear from the outset that Oremland has taken up this challenge with the seriousness and devotion it deserves. He has read everything, looked critically, and brought imaginative new perceptions to the study of this monumental work, in the context of the whole of Michelangelo's *oeuvre* and the art of the High Renaissance in general. If, in the end, his argument fails to convince, it is not for want of scholarly resource or psychoanalytic acumen.

Briefly, Oremland's position is that, from the outset, Michelangelo, rather than Julius II, was in full command of the program for the Ceiling and that he used it to represent an essentially heretical humanistic thesis—namely, that God is the creation of mankind or, rather, that God is a metaphor for "the awesome creativity of humankind" (p. 124). Further, he argues that the essential subject of the Ceiling is the ontogenesis of the human self. Indeed, Oremland finds in the very formal organization of the Ceiling a representation of the early stages of personality development in an object-relational framework. Michelangelo, he suggests, intuitively

[2] Sterba, R. & Sterba, E. (1956): The anxieties of Michelangelo Buonarroti. *Int. J. Psychoanal.*, 37:325-330.

[3] Peto, A. (1979): The Rondanini Pietà: Michelangelo's infantile neurosis. *Int. Rev. Psychoanal.*, 6:183-199.

[4] Liebert, R. S. (1983): *Michelangelo. A Psychoanalytic Study of His Life and Images.* New Haven: Yale Univ. Press.

[5] Leites, N. (1986): *Art and Life. Aspects of Michelangelo.* New York: New York Univ. Press.

anticipated modern develomental psychology's understanding of the gradual differentiation of self from non-self in the context first of the evolving mother-infant dyad and then of the triadic family.

Oremland's method involves the treatment of the work of art as equivalent to a dream. In doing so, he looks for clues to meaning in patterns of formal structure and sequence, using the artist's actual ("topical") experiences and relations as, in effect, day residues, and seeking to find metaphoric reference to early developmental events and interactions and to universal archetypes. He sees in the formal plan of the Ceiling a pervasive tripartite order which, he maintains, "formally recapture[s] the human developmental phases." "In essence," he says, "the Ceiling as a condensation of the unitary, binary, and the ternary is a visual metaphorical chronicle of the ontological sequences in the development of the individual" (p. 131). "God becoming humankind is the metaphor for a living creature becoming a human being" (p. 131).

Illustrative of this method, and central to the argument, is an extended consideration of what Oremland maintains is Michelangelo's alteration of the biblical sequence of events in the "Noah" triptych—the presentation of the "Sacrifice" before, rather than after the representation of the "Deluge." In his "reading," this "near-heretical alteration" reflects Michelangelo's efforts to "reveal his full understanding" of "incestuous, murderous intrafamilial feelings" (p. 104). He takes explicit issue with Esther Dotson's[6] explanation of this "reversal" as an expression of the influence on Michelangelo of Saint Augustine's commentary on the sequence, one that is known to have been highly credited in the court of Julius II through its interpretation by the important theologian Egidio Di Viterbo. Unfortunately, Oremland offers only his own "reading"—well reasoned though it be—in evidence for his own radical contention.

It is, in the end, on such rocks as these that Oremland's argument founders. For this reader, at any rate, it is difficult to believe that the still relatively young Michelangelo could have succeeded in flouting Papal orthodoxy with a heretical, humanistic message in the very heart of ecclesiastical power and authority, or that his

[6] Dotson, E. (1979): An Augustinian interpretation of Michelangelo's Sistine Ceiling. Parts 1, 2. *Art. Bull.*, 61:223-256, 405-429.

intuition about human ontogeny could have superseded current theological doctrine as the basis for his program.

Like John Gedo, who provides a sympathetic but critical "response" following Oremland's text, I understand Michelangelo's religious views at the time to have been more deistic than humanistic; indeed, to accept Oremland's interpretation would be to credit Michelangelo with having prefigured the Enlightenment by two hundred years. Similarly, I find the "developmental" analogies provocative but forced.

Nonetheless, this is a serious scholarly essay, intelligently argued, well illustrated, and richly documented. It combines a concise but comprehensive review of psychoanalytic theories of creativity with an innovative approach to a specific work and its place in the history of art, the life of its creator, and the times in which it was executed. Far beyond most such efforts, it gives full place to the role of style and artistic convention and does not, as Gedo points out, rely primarily on "evidence" from the artist's (putative) psychopathology (though the inevitable question about Michelangelo's homosexuality is discussed at some length). Oremland makes a strong case for creativity as a means of achieving, in fantasy, a transitory reunion with primal objects. In this he comes close to the position advanced by Gilbert Rose[7] whose work he does not cite here. I am not sure, however, that this argument is advanced by referring to the process as a "regressive dedifferentiation," nor do I share Oremland's view that Greenacre's ideas about the constitutional roots of creativity are "unfortunate."

In her "response," the art historian JoAnne Bernstein says, "Oremland deserves much credit for aligning the individual and the universal, the mythic and the psychological" (p. 162). Indeed he does, and, although he does not fully succeed, his effort richly repays the reader's attention—particularly if that reader is as passionately concerned as he with the transfiguring magic of art and the unfathomable mystery of its creation.

AARON H. ESMAN (NEW YORK)

[7] Rose, G. J. (1980): *The Power of Form. A Psychoanalytic Approach to Aesthetic Form. Psychol. Issues*, Monogr. 49. New York: Int. Univ. Press; (1987): *Trauma and Mastery in Life and Art*. New Haven: Yale Univ. Press.

HELPING YOUNG CHILDREN GROW. "I NEVER KNEW PARENTS DID SO MUCH." By Erna Furman. New York: International Universities Press, Inc., 1987. 427 pp.

Erna Furman has given us a book in which we can observe and experience what is taken for granted by many analysts: Heinz Hartmann's "average expectable environment" and D. W. Winnicott's "good enough mother." Furman discusses child development as derived from her extensive experience as child observer, nursery school teacher, educator, parent therapist, and child psychoanalyst. It is not a presentation of a comprehensive theory derived from formal observation and research in child development.

The basic material of the book, which is written clearly in everyday language, has been used successfully for many years in courses on the psychoanalytic theory of child development for high school seniors. The material has been also used with many groups of parents and professionals at all levels of sophistication at the Cleveland Center for Research and Child Development. Although the volume is written in nontechnical terms, this does not mean that Furman's premises about child development or her questions and discussions of issues concerning it are simple or simplistic. She does not eschew complex or controversial ideas, as is illustrated by the following statements: "Nudity is natural. I think children should see their parents in the nude from the start because then they will not think of it as sexual" (p. 325). "Are the aggressive urges really innate or are they a response to frustration?" (p. 281).

We may not agree with her views or conclusions, but she states in her introduction that that is all right. She wants the readers to do their own mental work, to see the issues more clearly, to marshal their own thinking and experience, and to pinpoint their areas of uncertainty.

The book is organized into three parts with numerous sections in each. The format is in the nature of a Socratic dialogue with bold headings of topics such as, "What, if any, are the lasting damages of inadequacies, interruptions, or changes in mothering?" (p. 25), followed by Erna Furman's thoughts on the subject.

The material is heavily weighted, though never exclusively, to-

ward the influence and effect of relationships in a child's development. Part I is called "Relationships." The sections range in their focus from the first relationship of mother and baby, through relationships with baby-sitters, relatives, and friends, to the teacher-pupil relationship. Even though Part II deals with self-control and mastery and Part III deals with needs, urges, and feelings, they are viewed from the vantage point of the second part of the title, "I Never Knew Parents Did So Much." She shows what the average to optimal expectable environment can be and what happens in the many instances when it is not. She brings to life the objects in object relations, without scanting the importance of instinctual drives and ego endowment.

Unless one is a student, teacher, or reviewer interested in reading the book in sequence from start to finish, I would heed one of Erna Furman's recommendations in her Introduction to "not hesitate to skip around, to read later chapters, or parts of chapters, first."

The analytic reader may gain a broader appreciation of what is contained in the average expectable environment in which the ego, mental apparatus, or self develops. Freud stated that "the character of the ego is a precipitate of abandoned object-cathexes and that it contains the history of those object-choices."[1] Loewald spoke of the internalization of object relations. Much of the character of these relationships is unobservable to us in the analytic situation. They have become part of the analysand's mental structure and their development and rich nature are not readily accessible. Similarly, mature superego values are depersonalized. This book may help us to be more attuned to the nuances of patients' distortions in their description of their early object relations, related to states of the child, thwarted wishes, levels of ego development, and so on.

As I read through the book, I discovered a panoply of deceptively rich psychoanalytic ideas and questions that were presented easily in everyday language. However, none would be new to the analytic reader. On page 317 are examples of the transformation of instinctual drives, "when mixing dough deteriorates into real messing." On page 281 she discusses whether aggression is a drive (she uses the word innate), something learned, or a reaction to

[1] Freud, S. (1923): The ego and the id. *S.E.*, 19:29.

frustration. On page 357 she talks about Max Schur's ideas about somatizations and affect equivalents in her own words. "He was not bodily ill but still felt his anger in a bodily way. . . . The sooner children are helped to know their feelings and to express them effectively in words, the sooner are their bodily processes freed from the burden of discharging them."

In conclusion, this book has something to offer to anyone who works with children or is interested in child development. Any teacher of child development will be pleased to have such an able assistant. Although nothing new is offered to the reasonably well-read psychotherapist or psychoanalyst, such a reader might nevertheless enjoy revisiting the "average expectable environment" of the developing child.

ALLAN JONG (NEW YORK)

DEVELOPMENT, GENETICS AND PSYCHOLOGY. By Robert Plonim. Hillsdale, NJ: Lawrence Erlbaum Associates, 1986. 372 pp.

Our understanding of the importance of behavioral genetics for psychoanalysis, as reflected in Robert Plonim's book, starts with a concern for the relationship between heredity and environment, the nature versus nurture issue. Interestingly, we have learned from the study of molecular and cellular biology that hereditary influences change over the course of development. It is not only that we are born with a set of genes that are important determinants of later development, but that hereditary influences come in at different times and in different ways. Thus, heredity influences us not only early in development but later as well, affecting both normal behavioral development and disorders.

We know from studies of behavioral genetics that there is an interaction between heredity and environment. In emphasizing this interaction, Plonim stresses that one of the most important findings to emerge from human behavioral genetics involves the impact of environment on hereditary factors. Researchers have come to the remarkable conclusion that environmental factors can, at times, make two children from the same family as different from one another as are pairs of children selected randomly from the general population. Yet, the greatest environmental influence is the family, which affects each child differently. This accounts for

differences in personality and even in psychopathology. Neither the genetic makeup that comes from being born into a family, nor the environmental influences from being reared in the family, can solely determine the incident of psychiatric disorders or the individual differences between family members; complex interactions between the family environment and the genetic predispositions are of major importance.

As noted, the influence of genetic factors is apparent throughout development. Family concordance rates reported recently for schizophrenia indicate about 10% concordance for first-degree relatives. For fraternal twins, the rate is only slightly higher than 10%, and for identical twins, it is less than 50%. Similar results suggesting genetic factors and hereditary similarity are found for those with manic-depressive disorder.

In a recent article, Emde[1] has provided an integrative perspective on the importance of behavioral genetics for psychoanalysis. Population genetics, as he prefers to label the area, tells us a great deal about environmental influences on psychopathology. With schizophrenia, the risk of the disorder is as great when individuals from at-risk families are adopted in infancy as when they continue to live in their own families; this points to the importance of genetic factors. However, since the concordance rate for schizophrenia is slightly less than 50% even for identical twins, other influences, of an environmental nature, seem to be important. Consistent with this concept that non-genetic factors are also of importance is the striking finding that more than 90% of schizophrenics do not have a first-degree relative who is schizophrenic.

Plonim emphasizes that through population studies, we have learned that hereditary influences on behavior occur throughout the lifespan, with different influences occurring at various ages. Thus, whereas previously it was thought that genetic factors were set at birth, current evidence indicates that genetic influences change over time and that some factors may be more influential at certain time periods than others. Some genetic factors are more influential in early infancy and do not increase in importance over time. Other factors may influence development at a later point.

[1] Emde, R. M. (1988): Development terminable and interminable. I. Innate and motivational factors from infancy. *Int. J. Psychoanal.*, 69:23-42.

This is of importance in psychiatry since some psychiatric disorders are more likely to occur at certain stages of development (i.e., schizophrenia during late adolescence). In understanding the causes of psychiatric disorders, information about the specifically experienced environment and the important interaction between genetics and environment is also crucial. Different genetic and environmental influences occur throughout the lifespan, with important effects on adaptation.

According to Plomin, a critical issue for developmental behavioral genetics is the study of genetic sources of change and continuity. Because such data depend on longitudinal studies, information is not readily available. At present, we know more about the relative contributions of genetic and environmental factors to variance at each age, but cannot assume that the findings at one age will generalize to any other age because much of the data depends on the more readily available cross-sectional information. The general question to be answered by longitudinal data is the extent to which genetic and environmental factors at one age co-vary with those at another age. Plonim emphasizes that, in addition to the contribution of genes to change and continuity, the best way to study nurture is through the study of nature. We can learn much about environmental influences, especially about the nonshared variety that is so important in development, from our studies of genetics.

Plonim's book *Development, Genetics and Psychology*, is carefully written. It presents complex material in an understandable manner, for clinicians as well as researchers. It provides us with an opportunity to expand our understanding and perspectives on the roles of heredity and environment in development. I can highly recommend the volume for the interested psychoanalyst or psychoanalytically oriented reader.

JOY D. OSOFSKY (NEW ORLEANS)

TALES OF LOVE, SEX AND DANGER. By Sudhir Kakar and John Munder Ross. New York: Basil Blackwell, 1986, 1987. 249 pp.

The book is dedicated "To lovers." As the title suggests, it does not aim to achieve a scientific definition of love. The subject is considered from different points of view: in the traditional view of Freud,

as a psychology of love, transference being its prime manifestation; and through the eyes of poets and writers, historians, sociologists and cultural psychologists. The authors themselves, coming from two different cultures, examine love stories of various eras and cultures: Western, Perso-Islamic, and Indian-Hindu. Subjected to analysis are *Romeo and Juliet*, the Indian tale of Rhada and Krishna, Middle-Eastern love stories, and others. Interspersed are occasional clinical vignettes. The authors' approach, similar to Erikson's, is to link life history to historical and cultural context. They believe that each individual and each culture, at various levels of consciousness, "stamp their imprint, their variations, on universal themes—emphasizing some of love's dangers and exultations while obscuring others" (p. 9). Each story, they believe, sets in relief the particular theme of loving which seems alien to the culture from which the tale has emerged, alien because it is an aspect of loving which that culture is intent on denying.

According to the authors, the erotic impulse contains something inherently demonic and destructive. All social institutions concern themselves directly or indirectly with the control of this impulse, which is usually achieved by denial, taming, and limitations. Occasionally there arises a social institution which appears not to control and limit this impulse, but to expose, represent, and give voice to it. Such an institution, the authors suggest, was psychoanalysis in its inception. When this happens, however, society's need to erect a bulwark against the feared impulse brings it about that this radical institution is gradually conscripted to the conservative requirements of society; thus the psychoanalytic attempt, in the authors' view, to understand such a text as *Romeo and Juliet* ends up cloaking rather than expounding its message. The model of this Janus-faced effort is represented in Shakespeare's play by the position of the church: the manifest content of Friar Laurence's action is to aid and abet the lovers; the latent content is to exploit the death of the lovers for the reconciliation of the warring families and "to create a more merciful Christian climate in Verona" (p. 33). Examples from Islamic and other love tales are given which make the same point.

Apart from viewing each love story in its cultural context and meaning, the authors also attempt to analyze it in terms of the individual life history, emphasizing particularly the early stages of childhood. Thus, they try to organize the voluminous material in

terms of its internal hazards, depending on the nature of the love relationship, dyadic or triadic, and its external manifestations and consequences. The authors maintain that "there can be no love without sex, that is, without its real or imagined or sometimes unconscious enactment in the sexual embrace of two persons" (p. 5). "Inevitably . . . a host of psychic dangers arise" (p. 5). Among them, the fear of helplessness or the fear of devouring those we love is present even in the prototypes of romantic, pure love. Thus, the authors view the lovers, Romeo and Juliet, as less endangered from without than from within. They speak of "the secret of erotic love, its synthesizing illusion," as most likely "based at the junction of two primal developmental dilemmas—the impossibility of oedipal possession and the half-wanted birth of the self" (p. 7). What is feared is also what is desired, and they maintain that there is no love without fear. Hence "the tales of love are also tales of terror and torment" (p. 6).

Throughout the book, the authors emphasize that madness is an important aspect of love. They are critical of psychoanalysts who view Romeo and Juliet as "real" people rather than archetypes, and who view their struggles as attempts to sever their "so-called incestuous ties to Oedipal parents," or Romeo's craving for Juliet as "his merely childish yearning for mother love." By contrast, the authors wish to elaborate in their own words on

> the savage, deathly, heavy passion harboured in the bosom of these two light lovers. . . . It is the rapacity, the urge to give oneself to eternal sleep, the grip of union, the surrendering of a sexual bounded identity and self-immolation which savage their tender love for one another (p. 37).

Kakar and Ross remind us that Freud viewed love as a form of insanity and that clinicians can only try to help such "madmen" to find protection from themselves and should not try "to tame" them.

The next story to be examined is the Persian tale of Layla and Majnun (mad man), who are seen as the "quintessential lovers of the Perso-Islamic world" (p. 43). Their story is viewed as an organizing myth of love that is representative of its culture. In contrast to the Christian concerns with chastity and the Hindu preoccupation with aestheticism, the authors point out that in most Islamic societies there is a "cheerful sensuality." However, it is mostly men

who benefit from the culture's permissiveness. As in other patriarchies, we are told, there lurks the psychic reality of man's deep-seated fear of woman's power. "The terror is of women who extract their revenge for their typical denigration and exploitation" (p. 53).

Two views of women are portrayed in the story of Layla and Majnun; the adored, idolized one and the treacherous female concerned primarily with her own sexual passions. This dichotomy is presented as an important theme in Islamic culture, though it is not exclusive to it. It is seen as an "exaggerated male attempt at dominance" in the service of defense against, as well as provoked by a "vengeful female rapacity" (p. 54).

In the conclusion of the chapter on love in the Middle Eastern World, the authors point out that fascination with passionate love points to the hope of man to resolve two paradoxical quests: the wish for oneness with the beloved, and the desire "for sensual excitement, sexual possession and orgasmic release" (p. 63). The character Majnun, in his unconsummated love in the tale of Layla and Majnun, embodies the first of these quests and its terror. In analyzing this tale, the authors attempt to understand it on different levels of meaning, but they focus particularly on the terror connected with the wish to merge with another person. Consequently, they view love's greatest danger as weakening the usual defenses which make lovers vulnerable to primordial anxieties. The authors arrive at the conclusion that both Romeo and Majnun express pregenital wishes—erotic wishes of infancy. Romeo is driven "to seize, possess and devour his Juliet. . . . Majnun, on the other hand, abstains . . . to avoid destroying his beloved through his omnivorous hunger" (p. 72).

They generalize that man's erotic nature, apart from being phallic, contains the wish to be "a babe in arms," as well as to be a woman. They reason that the "phallic illusion" of modern man has denied legitimacy and reality to these wishes and has therefore led to an oversimplification of man's erotic nature (p. 73). Man's wish to be a woman is distinguished from pathological cases of homosexuality, but is viewed as another remnant from "the prehistoric experience with our mothers" (p. 99).

In the second half of the book, the authors turn to an examination of triangular relationships. In a chapter entitled "Kings and

Cuckolds, Passion is Power," the emphasis shifts from tales of madness and unbridled instinct to tales of conflict and ambivalence, with the protagonists' inevitable confrontation with internal constraints. In this context, the stories illustrate love as well as conflict between fathers and sons, issues of conscience and their intrapsychic dangers: fears of castration, loss of love, and guilt. The myths of Tristan and Isolde, the Persian story of Vis and Ramin, and Indian legends in which father-daughter incest plays a role illustrate the above. However, the authors emphasize that "straightforward oedipal triangles" seen from the vantage point of the son alone are not their main focus. We are told that sexual rivalry between father and son in Islamic and Hindu tales does not represent the mother as necessarily the object of desire, at least not manifestly. Rather, "the battle centers on daughters and their surrogates" (p. 108) and the focus shifts from the son's incestuous wishes for the mother to the father's illicit desire for his daughter.

The Oedipus myth is re-examined and, in seeming agreement with Erich Fromm, the authors interpret the myth as concerning itself more with patriarchal power struggles and parental violence toward children than with the child's incestuous yearning. Hamlet and the story of Tristan and Isolde are used to illustrate the incestuous heterosexual aspects as well as the love of the father by the son and the father's love for the son. Islamic and Indian tales are omitted from this chapter, with its emphasis on unconscious guilt, because guilt as a primal danger of love, according to the authors, is absent in the cultures named above. Guilt, there, is more related to man's sense of imperfection than to the sinfulness of sexual love. In the Hindu view, man's ignorance of his essential nature is the "core, psychoreligious issue," different from the Judeo-Christian tradition, from which psychoanalysis is derived, in which guilt is central to human development.

Discussing the phenomenology of love, the authors begin with Freud's original dualistic theory of love as two currents, the sensual and the affectionate. They turn to the later developed dual instinct theory, in which libido and aggression become the essential elements of human psychic life; then they examine various unitary theories of love in which aggression plays the principal role—theories of Sartre, Briffault, and others. In the end, in contradiction to their earlier assertion, they contend that aggression is *not* the cen-

tral theme of love, though "an inevitable corollary," and that in passionate love, the wish to preserve, adore, and cherish the object of one's desire plays a significant role. In accordance with Freud's original idea of a "tender current," the authors speak of it as "longing" which, with desire, gives rise to "romantic erotism." In an analysis of longing, idealization and identification are viewed as important elements, yet only as preliminary achievements in the work of longing "designed to jar the soul out of its narcissistic sheath" (p. 204). The authors, taking issue with contemporary psychology, "which frequently views seemingly external events as projections of internal ones," believe that, for instance, love at first sight does occur and that "lovers are more than shadows projected on the screen of their individual unconscious infantile past" (p. 214). They believe in an alchemy beyond analysis.

Finally, in the last chapter, called "The Ontogeny of Love," Nabokov and his relationship to his mother is used as the prototype of male sexual development, with excerpts from various of his writings: *Speak Memory*, *Lolita*, *Ada*, etc. They speak of him as an "apt rendition of the very object relations theory he himself would have found an anathema" (p. 219).

The authors put great emphasis on the importance of early object relations and the vicissitudes of the mother-child relationship in explaining the phenomenology of love. They make a passionate plea for tolerance of love's madness, which they consider inevitable. In persons whose self-esteem is very low and whose vulnerability is very high, as in those with narcissistic character disorders, this certainly is true. Whether love's "primitive dangers" as described by the authors are a general clinical finding is extremely debatable; it depends, I believe, on the theoretical bias underlying our observations. The book contains a wealth of references on love and sexuality in world literature.

The tales are interesting and their analysis often intriguing; all of them are written by men and are interpreted by the authors—also men. This may account for an important deficiency of the book: there is no independent concept of female sexuality. While there is a recapitulation of Freud's theory on libidinal development, none of the literature on female psychosexual development since Freud is mentioned, and female sexuality is seen predominantly as complementary to that of the male.

The style of the book is unfortunate; it strains for effect at the expense of clarity. Here is an example:

> Each great love story contains all others in that it includes within its gambit all of love's paradoxical associations and radii—conquest, possession, surrender, the savouring of unbearable and raw transports, time held still in a poised nostalgia, sensuality and sensuousness, and the loss of visual, distal perceptions in another mode of knowing (p. 9).

The meaning of such passages is elusive.

ILSE K. JAWETZ (SAN FRANCISCO)

CHURCHILL'S BLACK DOG, KAFKA'S MICE, AND OTHER PHENOMENA OF THE HUMAN MIND. By Anthony Storr. New York: Grove Press, 1988. 310 pp.

The essays by Anthony Storr in this uneven volume are tenuously tied together by the theme of creativity. Thus, we are told that Churchill's creativity can largely be seen as a courageous attempt to keep his "black dog" (the nickname by which he referred to his recurring bouts of depression) at bay.

To bolster his argument, Storr calls upon the typologies of Sheldon and Jung to describe Churchill as doing battle with his inner nature in order to ward off the underlying depression. Much of the evidence marshaled by Storr to validate his hypotheses about Churchill and others comes from this own rather idiosyncratic and eclectic approach to psychiatry. This is not to say that he does not utilize Churchill's own writings in his attempts to understand the man, but that he too often gives equal credence to his own biases.

When he turns to the facts of Churchill's life and to an investigation of his works, I see him as being on firmer ground, though his generalizations even in this sphere disturb me. Thus we are told that both of Churchill's parents were rejecting and that the consequent deprivation he suffered was the underlying cause of his feeling that he was "special" and of his intense ambition to prove this to the world. Further, Sir Winston is seen as having turned his hostility for his parents inward and to have idealized them. His later rage at Hitler is seen as an externalization of the anger toward his parents, which also served to help ward off the underlying depressive feelings. I should note here that rather interesting documentation from Churchill's writings is added, which illustrates

how he used creativity to mobilize his aggressive feelings and to bolster his self-esteem.

In describing Kafka's lifelong problem with his sense of identity, Storr advances many of the same ideas about the pathological effect of early parental deprivation that he used to explain Churchill's depression. One is left with the feeling that the explanation is simplistic and overgeneralized.

Again, when Storr turns to the facts of Kafka's life and to his writings, he brings us much interesting material about the abuse he suffered at the hands of his father, who constantly negated him as an individual. Storr sees Kafka's feelings of being powerless in his external world as leading to his turning to an inner world of fantasy. No useful ideas are advanced, however, as to why this should have specifically led him to expressing these fantasies in creative writing.

In Storr's essay on Newton, the great scientist's paranoid and depressive traits are traced to his sudden maternal deprivation at the age of three. Storr then links Newton's presumed feelings of early helplessness and distrust with his later attempts to solve the greatest scientific problems of his day and to gain control and mastery of the world around him. While this may or may not be true, Storr really does little to inform us about just how this might have occurred.

Storr's essays on C. P. Snow and William Golding are paeans to his tutor at Cambridge and to a close friend. In his work on Othello's jealousy, the central issue in the Moor's life is seen as being the threat to his basic attachment (in Bowlbian terms) to Desdemona, rather than the presumed slight to his sexual pride. Even here, since there is no actual patient or even any real person who might provide corroborating data, the viewpoint seems imposed from without rather than derived from within.

In his chapter on adult development and in his essay on Jung's psychology, Storr emphasizes his belief that psychological development continues well beyond the oedipal years and adolescence into mid-life and even later. For Storr, Jung's major contribution is his belief that mental illness results from a disunity of the personality and that mid-life crises often help us to achieve higher levels of integration and Schopenhauerian "individuation" than we had before. This need for integration is also seen in the paper, "The Psy-

chology of Symbols," in which music is seen as symbolizing man's attempt to make sense out of existence by imposing order and unity upon it.

The essay, "Psychoanalysis and Creativity," attempts to disprove Freud's ideas that the motivations of artists and scientists can be sharply distinguished. Storr advances the thesis that play, fantasy, and dreaming, which Freud saw as escapist, can equally well be regarded as adaptive and concerned with creating order and mastery. In the paper, "Why Psychoanalysis Is Not a Science," the idea offered is that Freud's shift from an objective to a subjective approach to patients disturbed his scientific vantage point.

In "Sanity of True Genius," Storr notes that it is unjustified to link creative or scientific inspiration with mental illness, even though the individuals involved in such endeavors may have a greater than average susceptibility to mental illness. He further sees creative work as a protection against mental breakdown, inasmuch as it protects against the dangers of intimacy and may lead to greater self-esteem.

The final two essays in this volume deal with why people are violent and with the responsibility of psychiatrists in our society. In the former, Storr sees violence primarily in terms of revenge against early parental ill treatment, and in the latter, he urges psychiatrists not to be participants in the questioning of political prisoners, which he sees as a perversion of creativity.

In sum, while these essays on creativity are often interesting, the problem for me lies in Storr's idiosyncratic methodology. He imposes ideas from without rather than deriving his hypotheses from within, and he is frequently guilty of the genetic fallacy of saying that because something existed in a person's early life it must have been causally influential in his later work. As a result, the book is quite disappointing.

WAYNE A. MYERS (NEW YORK)

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James R. Edgar

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ABSTRACTS

Psychoanalytic Inquiry. VIII, 1988.

Abstracted by James R. Edgar.

Character, Dyadic Enactments, and the Need for Symbiosis. John E. Gedo. Pp. 459-471.

Gedo traces the history of the controversy over the intrapsychic and the interpersonal, suggesting that the concept of character ("a set of structured mental dispositions that mediate the individual's transactions with his environment") be used to bridge the two realms of discourse. He sees a tendency toward polarization and gives reasons for it. In its most polarized form, the conflict is between those who feel that the crucial issue in character formation is the resolution of the oedipus complex and the way one comes to deal with intrapsychic conflicts typical of this period, as opposed to those who focus on self-esteem regulation and autonomy related to pregenital phases and the influences of earlier infant caretaker transactions. Those patients with a predominance of pregenital influences on their character development will tend to form more archaic transferences, the most frequent being what Gedo calls therapeutic symbiosis. Going beyond Kohut, Gedo says that there are many forms of archaic transferences and that these are "adaptive maneuvers acquired in childhood in order to compensate for some preexisting deficiency." These "archaic transferences" lead to "dyadic enactments" within many analyses without being acknowledged. He suggests we pay more attention to these dyadic enactments in a systematic way, as he believes that the failure to respond to needs inherent in these archaic transferences will lead to premature interruption of an analysis. These dyadic enactments do not preclude the establishment of a more classical analysis of oedipal materials.

The Intrapsychic and the Interpersonal: Different Theories, Different Domains, or Historical Artifact? Stephen A. Mitchell. Pp. 472-496.

The author discusses the relationship between "intrapsychic" and "interpersonal" from a Sullivanian perspective. He feels we have moved beyond the early polarization. The issue now is not a choice between intrapsychic and interpersonal, but the relationship between them. Mitchell traces some of the early history of the conflict, beginning with Freud's shift from a theory of infantile seduction (interpersonal) to a theory of infantile sexuality (intrapsychic). Sullivan's introduction of the term "interpersonal" in 1927 was not in opposition to Freud's theory but to Kraepelin's theory of dementia praecox, and was important because of his interest in treating schizophrenics. Sullivan's continued development of his theory was inspired by "operationalism," which dominated the natural and social sciences of his day. In this methodology meaningful scientific concepts had to be closely tied to concrete "operations." The more abstract a concept became, the more suspect it was. Operationalism caused Sullivan to become unhappy with Freud's theory after it changed. Sullivan felt it had moved away from actual experience to more abstract, invisible psychodynamic forces. He rejected Freud's concept of the individual mind as basic

unit of study. He felt that many intrapsychic concepts such as "internalization" are actually reifications of metaphors for early bodily experiences. Mitchell points to more contemporary theorists, such as Schafer, Loewald, Kohut, and Modell, whose ideas he feels are congenial to Sullivan's statement that "the human mind is part of a field, not a self-limited phenomenon in its own right." Although rejecting the motivational theory of drive, Sullivan felt that the intrapsychic realm has certain influence in how external reality is perceived and *elaborated.* He granted an internal fantasy world that is dynamic in the sense that it is an active force when faced with new experiences. However, this internal fantasy world consists solely of "residues of earlier interpersonal integrations." Sullivan felt there were other parts of the unconscious besides these internal fantasies. These he referred to as "immutably private" and felt they were unknowable to us. Mitchell asserts that the intrapsychic and interpersonal theories have become complementary.

Intrapsychic Versus Interpersonal: The Wrong Dilemma. Sander M. Abend. Pp. 497-504.

Abend feels the crucial issue is not intrapsychic versus interpersonal, but whether infantile sexuality is the most important force affecting character development and character formation. Clinical theories should continue to evolve as new data are available; examples are given. One should be cautious in changing theories, to ensure that changes not be made for personal reasons and that the changes within a theory be consistent with the remaining body of the theory. Abend feels all psychoanalytic theories have a "schema of intrapsychic forces at work" whether this is made explicit or not. Freud's interest in intrapsychic fantasy did not make the real experience less important. His central thesis was that "conflict and its consequences constitute the central concern of psychoanalysis." By conflict he meant "unconscious instinctual conflict of childhood origins." Abend shows how the metapsychology related to instinct and drive has changed within classical psychoanalytic theory, but he reiterates that even with the change, we still tend to see most drive derivatives as related to either sexual or aggressive strivings. He points to other factors (cognitive capabilities, biological and social development) that contribute toward making the oedipal period the crucial organizing phase for so much of what follows in life. Abend feels that this view does not detract from the importance of preoedipal or postoedipal development, but he cautions against the use of these other frames of reference when they are substituted for and not integrated with oedipal issues.

The Dialectic Between the "Interpersonal" and the "Intrapsychic": With Particular Emphasis on the Role of Memory and Representation. Daniel L. Stern. Pp. 505-512.

Stern focuses on the interaction of the intrapsychic and the interpersonal to understand how we create "representations" or "subjective psychic reality." He identifies five processes available to the infant to restructure her or his interpersonal reality to a "subjective psychic reality." Traditional psychodynamic operations are one of these processes. Stern's main focus is on the other four processes. The second process is the development of such capacities as perception, stimulus barrier,

and cognitive capabilities. Stern refers to the inability to differentiate self from other and the "normal symbiotic stage" as examples of "subjective psychic reality" due to the process of development. For these factors to persist in influencing subjective psychic reality past an early age, some degree of intrapsychic processes (defense against conflict) has to superimpose itself on development. The third process is "innate object related preferences and tendencies." Stern places these phenomena within the intrapsychic domain but says they are related to attachment tendencies directed at the interpersonal object. The fourth process is the process by which "lived events become memories, how memories are organized into representations, and then how these representations affect the subsequent interpretation of other lived events." The author describes an encoding of similar events, formation of a prototypic memory that conserves the invariant factors while discarding the rest. This prototypic memory will be a very conservative force when interpreting any current interpersonal reality and could be another explanation for repetition compulsion. The fifth process he calls "specific memories as distinct from prototypic memories": some singular event or item in memory is so potent that in interpreting the present interpersonal reality, one overlooks the more common or shared items in forming a subjective psychic reality.

Case Discussion and Position Statement. Herbert J. Schlesinger. Pp. 524-534.

This paper and the two that follow are discussions of the same clinical case from intrapsychic, object relations, and self psychology perspectives. The case, which is not abstracted here, was selected as typical, and the analyst involved was identified as having been classically trained.

Schlesinger's position is that of the classical intrapsychic analyst, and his focus of clinical attention is the microstructure of the analytic session. He discusses the case in terms of a dynamic unconscious and organizes the material with concepts such as transference interpretations, defense maneuvers, oedipal conflict, and penis envy. He gives a new metaphor for structural change and discusses his interest in the microstructure of the analytic session. Like the other two discussants, he is interested in knowing more about the actual give-and-take of the analysis. Although interested in what the analyst was thinking and feeling, he seems to pay more attention, compared to the other discussants, to the patient's reactions to the analyst. He focuses on the flux created by interpretation and the potential for therapeutic change brought about by this flux. Very specific and helpful examples are given of the patient's response to interpretations and the primary significance Schlesinger attaches to this.

Case Discussion and Position Statement. Paulina F. Kernberg. Pp. 535-545.

Kernberg's discussion is labeled an object relations point of view. She disagrees with other interpersonal object relations theoreticians (Sullivan, Guntrip, and Kohut), saying that internalized object relations do not reflect *only* actual past relations but combinations of actual and fantasied object relations and defenses against them. The more significant the psychopathology, the more interpersonal the clin-

ical picture appears. This does not necessarily mean that the etiology is more interpersonal. In the analysis of transference one can see the relationship between intrapsychic structure and object relations. Kernberg outlines how this occurs. She discusses empathy, attunement, and social referencing, the latter clearly an interpersonal phenomenon, and she underlines the importance of these for a successful analytic process. With this background she discusses the clinical material bridging the conceptual gap from intrapsychic defense mechanism to its expression as an interpersonal transference resistance. Her understanding of the basic intrapsychic conflicts of the case appears to be much the same as Schlesinger's. Her emphasis on empathy, social referencing, and framing the transference in interpersonal terms are interpersonal additions to his discussion.

Case Discussion and Position Statement. Ernest S. Wolf, Pp. 546-551.

Wolf discusses the case from a self psychology approach. He is primarily interested in the intrapsychic experience of the self and how this is *linked* to the extrapsychic interpersonal experience. He avoids attributing causality. Eschewing the sexual and aggressive motivations of the classical analyst, the self psychologist feels that behavior is motivated by the need to form a cohesive self. In this process there are certain self-evoking experiences that must be performed by the object in order for there to be a cohesive self. Clinically the self psychologist uses empathy and intuition to be attuned to the patient's experience of herself and the analyst. Wolf finds the case report lacking in the kinds of data he thinks most helpful: transference, countertransference, and reports of selfobject experiences. He then discusses the historical material in the case, showing what a self psychologist considers important. He focuses on the overstimulation and the unreliability of her real objective world and how these experiences would lead to a fragmented self. This fragmented self then leads to secondary behavior in an attempt to feel alive or whole. Wolf follows the treatment process and shows how he conceptualizes it in self-object terms. Sexual and aggressive material is seen as defensive against the underlying self fragmentation. He feels the analysis was useful to the patient not because of the interpretation of the oedipal material, but because the analyst's overall approach was accepting. He feels the analyst created a therapeutic ambiance in which inexact interpretations could be used by the patient metaphorically to make better sense of a fragmented self.

Real Frogs in Imaginary Gardens: Facts and Fantasies in Psychoanalysis. Edgar Levenson. Pp. 552-567.

Levenson feels that the current dilemma over interpersonal and intrapsychic is a new version of an age-old dichotomy of human existence, imagination versus experience. He feels both the intrapsychic and the interpersonal have to be taken into account when working with patients, and he gives some clinical material of his own to illustrate and illuminate his position. While the continued polarization is unfortunate, he does not feel the two polarities are synthesizable. For him, this is not the dilemma, but the answer. That is, we must stop trying to make one theory, and the

dichotomy must be accepted as necessary. Using the concept of creativity as "the ability to hold incompatible ideas simultaneously without resolution" as a beacon for psychoanalysts in this dilemma, he sees the resolution in accepting the inevitability of the conflict. He says that our clinical challenge is to decide which system is most relevant at what time and place.

Commentary. Robert Michels. Pp. 568-577.

Michels feels that good scientific dilemmas are not resolved, but lead us on to other dilemmas. The dilemma of the intrapsychic and the interpersonal has produced several new dilemmas. Is psychoanalysis primarily a clinical theory or is it a general psychology? What is the "critical period" of development that it should study? Some panelists suggest only the oedipal, others preoedipal and perhaps even prebirth. What are the sources and contents of intrapsychic life and how stable is it?

Commentary. Joseph D. Lichtenberg. Pp. 578-592.

The author feels the theoretical dilemma is not resolved, simply stated in different terms. There is an unfortunate tendency to "resolve" the clinical dilemma by saying both perspectives must be used. Lichtenberg suggests an alternative motivational theory encompassing all the areas he feels important. What we need now is a theory to help us understand how and why there is shifting dominance of motivations. He then reviews each presentation showing how the author either attempts to resolve the dilemma or frames it in new terms and raises questions for each theory that are intended to sharpen the argument. He does not go as far as Levenson to suggest that this dilemma or these derivative dilemmas are inevitable, but he does feel that our task as students of a theoretical science is to try to sharpen the issues and differences and, by accumulating the appropriate data, take the dilemma to its next stage.

Commentary. Arnold M. Cooper. Pp. 593-597.

Cooper sees the dilemma under discussion as related to an attempt to define the scope of psychoanalysis, and he argues for leaving it as open as possible. He underlines one particularly provocative idea from the conference at which these issues were discussed, namely, whether the oedipal phase is important because of the centrality of sexuality or because of the capacity for a new cognitive, narrative organization. While supporting the continued collection of data to test our theories, he reminds us that new theories come from the creative activity of theorists, not from data, in a process we know little about. He reviews the problems we have with our language and says we need a new one that will more clearly express our ideas.

Epilogue: Countertransference as the Interface between the Intrapsychic and the Interpersonal. David E. Scharff. Pp. 598-602.

Sharff feels we have now reached a time of synthesis between the intrapsychic and interpersonal perspectives. He suggests a careful study of countertransference phenomena would be most helpful in this synthesis.

Contemporary Psychoanalysis. XXIII, 1987.

Abstracted by Steven H. Goldberg.

The Interpersonal and the Intrapsychic: Conflict or Harmony. Michael Franz Basch. Pp. 367-381.

The author argues in favor of a unitary theory of psychotherapy, decrying the splintering of our field into various schools of thought. He believes that the dual instinct theory and the notion of the centrality of the oedipus complex are no longer adequate or viable models. He sees the brain as an "information-processing, not an energy-discharging organ." Its function is to create order and meaning from the myriad stimuli impinging upon it, a capacity that results in feelings of competence, which the author sees as the basis for self-esteem and the central motivation underlying human behavior. The therapist's task is to evaluate the patient's failure to achieve competence and to maintain self-esteem, and to assist the patient to "repair the damage and, if possible, to permit development to resume." The author views the intrapsychic and the interpersonal as two indissolubly linked perspectives, which he believes Kohutian theory is capable of uniting, in its emphasis upon the impact of the caretakers' ministrations upon the "unconscious expectation(s) that then guide future behavior." Specific forms of psychopathology are viewed as derivative of specific stages during which empathic failures occurred, and may be understood in terms of the defenses that are attendant upon such empathic failures. Several clinical vignettes are presented, representing different categories of pathology, in which the author feels that his interventions focused on the patient's difficulties, without slighting either intrapsychic or interpersonal reality.

New Views on the Function of REM Sleep in the Evolution of Mammals. Edward S. Tauber and Paul B. Glovinsky. Pp. 438-445

Several neurobiologists have been attempting to elucidate the neuropsychological basis of such psychoanalytic concepts as the unconscious, dream distortion, repression, and transference. For example, the half-second gap between brain registration and the completed sensory perception of stimuli is often cited as one experimental demonstration of unconscious mental activity. Regarding the functions of REM sleep, one prominent neurobiological researcher hypothesizes that REM sleep and dreaming serve processes of practicing and memory consolidation. Thus dreams are held to reflect "a cohesive, continually active mental structure which takes note of life's experiences and reacts according to its own scheme of interpretation and responses." This researcher traces the evolutionary development of REM sleep to its origins in mammalian development. Another prominent researcher has hypothesized that REM sleep functions in "reverse learning"—that is, the unloading of extraneous information which would otherwise overload neural circuits. The authors of the paper then examine the notion of critical periods for the integration of species-specific skills, along with the possibility that such critical periods may be related to changes in REM sleep, such as its well-known decrement with advancing age.

Ethnocentricity in Psychoanalysis. Miltiades Zaphiropoulos. Pp. 446-462.

The author attempts to explore transcultural factors as they may impinge upon psychoanalytic work. Ethnocentricity is understood in the double sense of a tendency to view individuals of another culture in terms of one's own, as well as a belief in the superiority of one's own group or culture. The understanding and practice of psychoanalysis are filtered through the prevailing culture and language in which any given analyst works. Attributes such as "psychological mindedness" may be difficult to assess when applied to an individual from a cultural background substantially different from one's own. The author differentiates between "allegiance" and "adhesiveness" on the part of the patient (or analyst) to "the tenets, belief systems, and experiential organizations" of the culture of origin. Allegiance refers more to prideful affirmation of the values of one's culture of origin, while adhesiveness refers to "sticky preoccupation" with one's original culture, which at times may take the form of compulsive opposition to or contempt for that culture. While areas in which the basic rule is violated may be fairly predictable in patients raised in one's own culture, this may be far less the case with patients raised in another culture. Symptoms and pathological character traits may be quite recognizable and similar to those of patients raised within the culture of the analyst, but notions of mental health, of the range of acceptable behavior, and of wished-for change may differ substantially. The practical arrangements and setting of psychoanalysis may have different meanings and be more problematic with individuals of different cultural backgrounds. The author suggests that there may exist ethnocentric aspects of psychoanalysis itself. For example, the oedipus situation, while perhaps universal, may be experienced and understood differently in different cultures. Ethnocentrically derived concepts may result in a "truncated view of another's human experience."

On Proverbs: Creativity, Communication, and Community. Stanley L. Olinick. Pp. 463-468.

Proverbs communicate "accumulated wisdom concerning character and interpersonal relations." There is a general form to which proverbs conform. They are compressed and witty, relying upon such literary tropes as metaphor and metonymy. Like dreams, they rely on condensation, displacement, and elaborative transformation. They convey a sense of community based on shared meanings and defenses, and establish a "common ground of friendly, soothing talk." While proverbs convey substantive information regarding character, interpersonal relations, etc., their primary meanings, according to the author, are contained in their form: "soothing, communal intimacy . . . an atmosphere of amicable mutual confidence, camaraderie, and a sense of community attained through the lure of benign authority and often witty counsel." They generally confirm existing mores and appeal to that aspect of the superego which is organized around group-sanctioned attitudes, although they may support anti-authoritarian attitudes. The proverb is seen as a type of story, arising out of personal experience, usually traumatic, and representing creative resolution of trauma within a communal setting.

Psychoanalytic Interpretation in Modern Clinical Perspective: A "Flight from History." Gerard Chrzanowski. Pp. 469-482.

An "interpersonal" perspective on interpretation is advanced, in which interpretations are viewed as "contact" rather than "content promoting therapeutic agents." The past, in this perspective, is seen as a "structuring element" in the present, and as subjective and contextual, rather than as objective and historical. There is a shift from a "vertical" historical focus to a "horizontal" here-and-now focus of analytic work. Interpretation is effective not so much because of the accuracy of its content as because of its capacity to establish rapport and to provide novel and development-promoting interpersonal experiences. It mediates a dialectical process between analyst and analysand that leads to the creative construction of "a truth [about the past] in the service of self-coherence."

Bulletin of the Menninger Clinic. LII. 1988

Abstracted by Sheila Hafter Gray.

Developmental Pathogenesis of Narcissistic Disorders in Children. Efrain Bleiberg. Pp. 3-15.

The concepts of narcissism that evolved to understand adult narcissistic disorders are inappropriate for the understanding of children, who are in the process of developing a self-image. During normal separation-individuation, the maturation of cognitive, motor, and perceptual abilities impels the child toward self-other differentiation. The child forms a concept of an autonomous, ideal self that is in harmony with both its inner needs and its outer reality. The child's own inner feelings and capacities for identification interact with actual experiences with caretakers to give this self-image its unique form. Narcissistic pathology tends to be a consequence of a mother-child interaction that tends to inhibit separation while allowing a significant degree of individuation to take place. Adopted children are particularly susceptible to fears of abandonment and are inclined to remain dependent while continuing their individuation. They construct grandiose defenses against their feelings of helplessness and vulnerability. These may be expressed in behavior or in a rich fantasy life. The author illustrates his thesis with a detailed report of the psychotherapy of a narcissistic, grandiose boy.

An Obsessional Variant of Capgras Symptom: A Case Report. Roy M. Stein and Steven Lipper. Pp. 52-57.

A thirty-five-year-old married woman suffered for two years from a recurrent, intrusive concern that her husband had been replaced by an impostor. She had similar worries that her parents, her cat, and even the city in which she lived had been replaced by duplicates. Careful psychiatric and psychological examination failed to demonstrate any psychosis. Her speech and thought processes were characterized by extreme attention to detail, and she pressed continually for reassurance. Soon after the patient left home for college at age seventeen, she was hospitalized because she developed ritualistic habits, compulsive hand-washing, and other

symptoms that rendered her unable to perform the ordinary activities of daily life. She was not helped by antipsychotic or antidepressant medication or by ECT; cingulotomy did provide significant relief. The present illness, characterized by obsessive doubts and worries, began after a single episode of marijuana abuse five years prior to admission. Then, following a stressful life event, the symptoms escalated until the patient came to question even her own identity. In this case, the authors postulate, the obsessive-compulsive defenses of isolation, undoing, and displacement produced the Capgras symptom as a solution for intrapsychic conflict.

Adaptation and Morale: Predictable Responses to Life Change. W. Walter Menninger. Pp. 198-210.

The author explores the vicissitudes of morale in Peace Corps volunteers and arrives at insight into the process of adaptation to new life events. He divides the Peace Corps experience into four time sectors. Arrival is characterized by anxiety, enthusiasm, and very high morale. Soon there is a crisis of engagement, when morale dips markedly as the individual experiences frustration, isolation, and depression related to real or fantasied losses. Acceptance of the situation is accompanied by moderately high morale as one develops techniques to master the new tasks and new patterns of personal relationship. The close of the tour of duty is accompanied by mourning that may conclude in satisfaction, hopefulness, and high morale, or depression, concern about the future, and low morale. These findings have broad implications for preventive psychiatry.

Adolescence, Sense of Self, and Narcissistic Vulnerability. Efrain Bleiberg. Pp. 211-228.

Psychoanalytic theorists have usually characterized regression and turmoil in adolescence as phase-appropriate and fundamental to successful adulthood. This opinion is contradicted by empirical findings which show that turmoil in adolescence is associated with significant adult maladjustment, while healthy adults have made a smooth transition from an earlier developmental phase to the next one. Bleiberg suggests that both positions reflect the notion that normal adolescence is a time of narcissistic vulnerability. The evolution of narcissism in adolescence echoes the progression from omnipotence to autonomy during the second and third years of life, and it is influenced by it. Biological, cognitive, and dynamic intrapsychic changes destabilize the young person's core self-image and exert pressure for the development of autonomous self-regarding and self-regulating functions. This achievement both depends upon and facilitates the resolution of the oedipus complex. A healthy adolescent serenely narrows the gap between ideal and actual self through affirmative expressions of new cognitive, adaptive, and social skills. Tumultuous behavior indicates that the adolescent is dealing with narcissistic vulnerability through regressive grandiosity or transitional activities that provide an illusion of self-regulation.

Widowhood: The Continuing Relationship with the Dead Spouse. Stephen R. Shuchter and Sidney Zisook. Pp. 269-279.

The authors interviewed eighty widowed people at regular intervals from one or two months after the death of the spouse until four years later. They identified a

dynamic conflict between the need to accept the loss and restructure one's life and the wish to maintain an emotionally vital, if illusory, relationship with the dead spouse. They found that the latter prevailed in most cases. Most participants believed their spouses had gone to heaven and that they would be reunited at a later time. During the earliest months of bereavement, the survivor sought out the dead person or even hallucinated his or her presence. Material symbols of the spouse and of the relationship, and memories of the deceased, took on special value for the survivor. Wish-fulfillment dreams, in which latent and manifest content are identical, assuaged feelings of loss. Some mourners solved the problem of separation in a series of leave-taking dreams. These findings prompt the authors to question the idea that the mourning process normally leads to decathexis of the lost object. Since we may expect that the relationship will persist, they recommend that psychotherapy be focused on helping the widow maintain it in an adaptive fashion.

The Psychology of Combining Dynamic Psychotherapy and Alcoholics Anonymous. Lance M. Dodes, Pp. 283-293.

The theoretical foundations of Alcoholics Anonymous and those of dynamic psychotherapy are essentially contradictory, yet many patients are able to use both at the same time. The author suggests that they do this by splitting the narcissistic transference. They tend to idealize Alcoholics Anonymous; and they express the major part of the mirroring transference and their structural conflicts within the formal psychotherapy setting. From this perspective, the dual approach may be seen as a technical variant of the treatment of any narcissistically vulnerable patient. In the short term, a narcissistic investment in Alcoholics Anonymous can help the patient remain sober long enough for psychotherapy to take effect. The patient's defensive use of the "disease model" of alcoholism expounded by Alcoholics Anonymous can be addressed dynamically as one would any other regressive pull that the patient experiences as beyond personal control. Ultimately, both the pathological drinking and the narcissistic investment in Alcoholics Anonymous may be interpreted. There is a well-selected bibliography.

The Patient as Selfobject: a Form of Countertransference. F. Diane Barth. Pp. 294-303.

We have paid insufficient attention to those countertransference reactions in which an analyst views the patient as a selfobject, someone who confirms or enhances the analyst's self-regard. Analysts may place their own needs before those of patients and engage in anti-therapeutic countertransference enactments. They may be angered by a regressed or resistant patient who makes only slow progress. They may experience and respond to a patient's free association that challenges their therapeutic effectiveness as if it were a comment about them rather than a manifestation of transference. The author believes that when narcissistic countertransference feelings occur, they are best used as a tool for understanding the patient. In many instances, however, the therapist's self-esteem may be subject to extra stress by a supervisor's comments that tend to cast doubt on the therapist's capacity for empathic listening. These may impede the unfolding of the transference. An effective supervisor will support the developing therapist's healthy investment in psychoanalytic work, and at the same time help the therapist discover the roots of a selfobject countertransference in the patient's transference.

Psychoanalytic Study of the Child. XLI, 1986.

Abstracted by Frederick L. Meisel.

Disposition and the Environment. Samuel Abrams, Pp. 41-60.

In a series of identical twins, separated at birth, one set had remarkably similar difficulties despite their different environments. Their difficulty is described as an "impairment in the inherent impetus," that is, "an interference in the blueprint of development that leaves the child with diffuse impediments to integration, structure and stability." This disorder was seen to override any differences in the families of these children. It left them with similarly disrupted development and resulting psychopathology.

The Empathic Wall and the Ecology of Affect. Donald L. Nathanson. Pp. 171-187.

Starting with Silvan Tomkin's theories of "innate affect," which provides the infant with neural systems allowing protective reactions to unwelcome stimuli, Nathanson develops the concept of an "empathic wall." Described as "a new ego mechanism," the empathic wall enables infants to define the difference between self and other, and protects them from unwanted or confusing states that result from intense affect. The author compares it to the defensive operations of denial and projection, and to projective identification. Clinical vignettes are given, illustrating the use of this concept with patients in therapy.

On Trauma. When Is the Death of a Parent Traumatic? Erna Furman. Pp. 191-208.

Differentiating trauma from stress, and excluding notions of cumulative, retrospective, and screen traumas, Furman restricts herself to the classical definition: "an influx of stimuli from within or without which breaks through the ego's protective shield and floods the system with excitation." Stemming from the inadequacy of the child to cope, from the overwhelming amount of stimuli, or from the failure of the parental environment to protect, the resulting trauma involves the interaction of internal and external factors, including immaturity and physical aspects of the events. Furman outlines various responses that differentiate trauma and stress, including "physical responses, vegetative excitement, massive anticathexis that is seen in states of shock, depersonalization, apathy, numbness and paralysis." These interfere with the ego's capacity for integration or synthesis and drive fusion. The process of recovery includes mastery through turning passive into active and requires "the development of signal anxiety in relation to experiences congruent with aspects of the trauma." Four vignettes with various degrees of recovery and mastery are presented, considering such factors as the child's age, pretraumatic vulnerability, and the availability of the parent in the post-traumatic period. Finally, Furman discusses the prevention of trauma, focusing on preparing the child if possible. She describes transference aspects of relived trauma during treatment of the child in psychoanalysis.

The Female Oedipus Complex and the Relationship to the Body. M. Eglé Laufer. Pp. 259-276.

Laufer states that the theory of phallic monism has been discredited by recent developments, and he asks that the consequences of that rejection for psychoanalytic theory be defined. In this paper he discusses the girl's awareness of her body as a container with openings and the expression of this awareness in later development. Laufer defines the girl's task as relinquishing the libidinal tie to the mother without having to find a symptomatic compromise through identification with the father or a masochistic submission to him. In other words, can the father and, later, other men be allowed into the space between the girl and her mother, or will his presence be felt as a threat which comes between her and her mother. It is the awareness of her body and the accompanying fantasies that determine the girl's ability to detach herself from her mother.

Talking with Toddlers. Kerry Kelly Novick. Pp. 277-286.

Novick presents a lovely vignette in which a toddler with night terrors is "treated" through the understanding and verbalization of her concerns about her ear infections, surgery, and feeling naughty and punished. A strong case is made for talking with toddlers in order to help them integrate their experiences, especially the traumatic ones. The author wonders whether our reluctance to talk with toddlers and our misunderstanding of their capacity reflect our wish to prolong their infancy and deny certain pregenital conflicts in ourselves and our children. We are cautioned about the impact on ego growth and learning that may result from our unwillingness "to hand over knowledge."

Consequences of Paternal Nurturing. Judith Fingert Chused. Pp. 419-438.

Chused describes a woman who was nurtured by her father in her early years. She discusses the effects of that nurturing on the woman's later capacity to have a satisfying relationship with a man and to enjoy her self and her life. Traumatized when her father, the primary nurturant figure, withdrew in response to her mother's two debilitating illnesses and pregnancy, the girl was left with a large amount of guilt in her rivalrous feelings toward her mother. Her pleasure in the early relationship with her father, as well as later oedipal feelings for him, was lost, and she was transformed from an outgoing, happy, boisterous girl into a withdrawn and sad child and adolescent. In adulthood she felt inadequate and had a series of unsatisfying relationships with rejecting and unavailable men. That analysis changed her is remarkable, for often this type of patient merely re-experiences her feelings and relations in analysis, in a negative therapeutic response, without being able to change. The beginning of the analysis was difficult, as the patient could only deny the positive aspects of the relationship. She did this in order to avoid re-experiencing the loss of her father and her guilt over damaging her mother. She wanted to be a male in order to repair her damaged sense of herself and to be closer to both father and mother. The exploration of these feelings led the patient to the more usual oedipal rivalry with the analyst and also to the recovered memories and feelings of her early, preoedipal closeness with her father, which was instrumental

in her eventual return to emotional health. This case illustrates that the father as primary nurturing object can function as a "good enough" parent in the preoedipal years. However, the question of the effect of paternal nurturing on later oedipal development and on the girl's capacity to withstand trauma is left unsettled.

The Specter of Genetic Illness and Its Effect on Development. Judith A. Yanof. Pp. 561-582.

A preadolescent girl with the possibility of a genetic illness revealed many concerns that were similar to those of children with congenital defects. The girl's struggle with questions about her intactness, defectiveness, and badness were tied to her feminine identity and her genitals. Furthermore, the vagueness and uncertainty about her illness was instrumental in the development of a cognitive style that avoided facts and details in favor of a more global, impressionistic, and maladaptive viewpoint. Her self-hatred, the unacceptability of either gender for herself, and her inability to free herself from a regressed connection to her mother were all worked through and ameliorated in this sensitive analysis.

Nursery Rhymes. A Developmental Perspective. Vincent P. DeSantis. Pp. 601-626.

Unconscious derivatives of the Mother Goose nursery rhymes are discussed, with an emphasis on the sexual and bodily aspects of these cryptic communications from parent to child.

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Meetings of the Psychoanalytic Institute of New England, East

Morris J. L. Stambler

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NOTES

MEETINGS OF THE PSYCHOANALYTIC INSTITUTE OF NEW ENGLAND, EAST

September 28, 1987. SELF INQUIRY. Rivka Eifermann, Ph.D.

Dr. Eifermann, President of the Israeli Psychoanalytic Society, has had a long-standing interest in the uses of self-analysis. In connection with teaching a course on dream analysis, she has analyzed her own dreams for many years. When she took part in a joint seminar on psychoanalysis and literature, she was disturbed by the tendency of some literary experts to "analyze" literary characters without any awareness of important differences between such attempts and the processes and products of clinical psychoanalysis, as well as of self-analysis.

Dr. Eifermann presented a method of self-analysis based on the recording of her dreams and associations. For Dr. Eifermann, as for many others, this type of inquiry is associated with a feeling of inner pressure. At times the pressure is manifest, while at other times various intellectual distractions and sublimations can obscure the full impact of the feelings. In her published work, Dr. Eifermann's goal has been to present meaning from within that could be used to advance general understanding. Her work expanded when she discovered that she could apply self-analytic methods to uncover underlying themes in her own writings. She has thus been able to understand material in ways that were previously unknown to her. For example, she described her analytic inquiry into a paper she had written prior to analytic training, a paper about children's games from the point of view of a developmental/social psychologist. She found that self-analytic inquiry was a "search method" that became a means of reaching new ideas and hypotheses hidden in the material, ideas that years of research had not brought into focus. Once the possibility of sharing publicly the processes and product of self-analysis is seriously considered, conflicted feelings about self-revelation arise. Dr. Eifermann discussed some of the problems that accompany the sharing of intense or intimate material. One must decide whether the inevitable loss of privacy is balanced by the hoped-for contribution. She also discussed a number of other problems that self-analysis presents. Nevertheless, she believes that it has some powerful advantages over the two-person analytic situation as a research tool. When self-analysis is practiced in the form of a written record, the entire process of the analytic endeavor is recorded and can be further explicated in ways impossible in a two-person ongoing analysis. Such written records lend themselves to research into processes leading to insight, or to the "eureka" experience, through a retracing of the antecedents of experience.

DISCUSSION: Dr. M. Robert Gardner pointed out how variably self-analysis is practiced. Each person engaged in the process will search for her or his own method with its own rules. Dr. Frances Bonner questioned the "eureka" experience. Dr. Eifermann responded by noting that recall of a lost detail, or finding the solution of a problem, can come suddenly when one is not immersed in the immediate ques-

tion. Revelation of a discovery is an exhibitionistic act. The story of Archimedes captures the fear of showing oneself and being found to be naked, in conflict with the exuberance of wanting to reveal what has been won. Dr. Evelyn Schwaber noted that the reverse could also be true, i.e., one could feel an exaggerated response to minor insights. Dr. Ana-Maria Rizzuto commented on the sense of pleasure and conviction when a "correct" interpretation or reconstruction is offered, whether this is in self-analysis or in regular analytic practice. Freud had referred to the central importance of conviction in his paper, "On Construction in Analysis." Dr. Schwaber said that the data of transference and countertransference are available to the analyst conducting an analysis. All the same, the analyst has a feeling of gratification that is like that experienced in self-analysis.

In a series of questions raised by Dr. Schwaber and by Dr. Morris Stambler, similarities and differences between two-person analysis and self-analysis were explored. Two-person analysis was felt to be more productive and less difficult, with a significant difference in the process of symbolization and verbalization. Dr. Stambler compared self-analysis to child analysis, noting that there was the problem of verbalizing an insight found in play. Similarly, in self-analysis, one has to take insight from the preverbal realm into the verbal to communicate it. Dr. Gardner commented that when self-analysis is practiced in a way that involves becoming flooded, it becomes necessary to make something of the process; making sense of things is the art of the psychoanalyst. Dr. Schwaber asked how the "making sense" was different in self-analysis, and Dr. Gardner replied that, as in the story of the sorcerer's apprentice, once the experience of an intense self-analysis is entered into, it has you in its power. Much pain and suffering may have to be endured until the relief of insight is accomplished. Dr. Rizzuto compared self-analysis to a religious ritual, in that it seems to contain some of the same crucial elements: expiation, purification, and offering. Dr. Arthur Valenstein commented that there are many ways in which analysts pursue their own insights, some preferring not to pursue their own thoughts so formally and intensely, but rather to realize them in the intersubjective endeavor of psychoanalytic practice.

MORRIS J. L. STAMBLER

June 6, 1988. AGGRESSION AND THE HISTORIAN: A PSYCHOHISTORICAL VIEW. Peter Gay, Ph.D.

Dr. Gay defined aggression as a wide spectrum of feelings and acts ranging from confident self-adventure to torture. He highlighted the influences that the psychic, social, and cultural milieus have on aggression, and he discussed nineteenth century middle-class culture as a specific example of how culture influences and provides "alibis" for aggression. Dr. Gay reviewed the history of theories of aggression. Included were the polar extremes of ethology and environmentalism. Ethologists conceptualize an innate and universal hostile energy pushing for expression; this is modeled on the animal observations of Konrad Lorenz. Environmentalists, on the other hand, deny an innate hostile core of human nature. They espouse what Dr.

Gay called an "oversocialized" conception of the human which he believes leads them to a politics of decency, moral pedagogy, and remedial social action.

Dr. Gay then reviewed Freud's writings on aggression. In contrast to the extremes of the ethologists and the environmentalists, Freud affirmed the plasticity of human nature, according to Dr. Gay. Although Freud's theory of a death instinct remains controversial, his balanced view of a dynamic interplay between drives and adaptation, which was previously known to poets, remains a useful model for the complexities of human nature. Dr. Gay discussed the difficulties of defining and understanding aggression, citing Anna Freud, Fenichel, and Stone. He commented on the frequent association of and interaction between love and hate, and on the adaptive and constructive components of aggression. He wondered, with Hendrick, whether a drive for mastery was a separate instinct or a derivative of erotic or aggressive drives. Dr. Gay concluded that certainty about these questions was not to be had from psychoanalysts or historians, but that a debate will continue among them.

DISCUSSION: Dr. Max Day asked whether the 1912 paper by Sabina Spielrein contributed to Freud's theory of aggression. Dr. Gay felt that her paper was a significant contribution, but that neither Freud nor anyone else at the time was receptive to it. Dr. Alexandra K. Rolde stated that mastery has components of intellect and of curiosity which are perhaps distinct from both libidinal and aggressive drives. Dr. Gay associated to Freud's comment to Fliess about the "intellectual beauty" of his book, *The Interpretation of Dreams*. He noted, however, that beauty is ultimately a result of sexual interest. Dr. Ana-Maria Rizzuto wondered about distinguishing between mastery and aggression. Dr. Gay agreed that this is difficult to do and depends upon one's frame of reference. He cited Voltaire's description of needing to clear the land before being able to build. Dr. Arthur Valenstein traced Freud's theories of aggression and the death instinct to his paper, "On Narcissism," in which he first described a non-libidinal egoism directly connected with self-preservative trends. Dr. Valenstein also shared his recollections of the 1971 Psychoanalytic Congress in Vienna on aggression and his sense that it was influenced by an environmentalist, social democratic philosophy. Dr. Gay agreed about the significance of the narcissism paper in the evolution of Freud's theory of aggression. He added that a desire to be different from Jung and not to be limited by only one drive were also operative in Freud's instinct theory. Dr. Peter Randolph asked whether Dr. Gay had not been overly modest in suggesting that historians had nothing to offer psychoanalysts. Dr. Gay asserted that historians have little to say directly to the clinician, but might be of use in the further development of theory and in the evolution of certain aspects of technique. He agreed with Freud that writing psychohistories of living persons might be using psychoanalysis as a form of aggression. Dr. Axel Hoffer concluded the discussion by asking for Dr. Gay's view, as a historian, on narrative truth, historical truth, and psychic reality. Dr. Gay responded that he recognized psychic reality as a valid concept with therapeutic implications. Nevertheless, along with nineteenth century positivists, he thinks that there is only one, not two, kinds of truth. He sees hermeneutics as modish and a retreat.

MARK F. POSTER

MEETING OF THE NEW YORK PSYCHOANALYTIC SOCIETY

April 26, 1988. **SHARED UNCONSCIOUS CONFLICTS, MARITAL DISHARMONY AND PSYCHOANALYTIC THERAPY.** Fred M. Sander, M.D.

After reviewing the very sparse analytic literature on marriage, Dr. Sander noted a rather casual aside of Freud's, made in 1919, in which he observed that an unhappy marriage can supersede a neurosis and can satisfy an unconscious need for punishment. Partners in such marriages use externalizing defenses and often do not seek individual treatment. Feeling victimized and blaming others can defend against depression and anxiety. Dr. Sander discussed the concept of shared unconscious conflicts, as the "unhappy marriage" requires a colluding and compliant "other." There must be shared internalized reciprocal or complementary identifications and fantasies, an idea which Dr. Harold P. Blum recently applied to Shakespeare's *Macbeth*.

Patients' choice of modality of treatment is often determined by defensive factors —e.g., the choice of conjoint therapy when separation conflicts are central. If psychopathology is viewed as a continuum from poor self-object differentiation, with primitive defenses, to higher levels of object relations, one can see that conjoint therapy is often initially necessary if the presenting and primary complaints deal with interpersonal conflict. After some individuation is achieved by the patients, individual treatment or analysis might then follow—or it might be indicated at the outset if the patient has the capacity to take responsibility for his/her internal conflicts. Dr. Sander presented two cases to illustrate the presence of shared unconscious conflicts. He concluded with the speculation that there may be fewer analytic patients these days because many neuroses are imbedded in marital disorders, which are increasingly being treated by therapists who are not analytically trained. Dr. Sander also discussed the usually polemical controversy over the relative weight of intrapsychic and environmental factors in neurosogenesis. He noted the frequency with which "external reality" is, in part, informed by a significant "other's" psychic reality, which leads to shared internal *and* external "realities." With such reciprocal internalizations, the distinction between external and internal "psychic" reality is not as discrete as we usually assume.

DISCUSSION: Dr. Donald Miller noted that Dr. Sander's paper may be the first from the field of family therapy to be presented at the New York Psychoanalytic Society after almost forty years of the co-existence of psychoanalysis and family treatment. What is new in Dr. Sander's clinical material is the recognition of the extent to which conflicts and fantasies are shared, the consequences of such sharing, and how much can be done to intervene. There was much in Dr. Sander's presentation that is useful for analysts doing analysis; for instance, his paper emphasized the need for heightened sensitivity to the dynamics of our patients' extra-analytic relationships. Family therapists become specialists in the mutual transferences of everyday life. Analysts can also profit from a heightened awareness of certain forms of resistance in which others share. Also useful would be an ability to make better informed decisions regarding referral for couple consultation and/or

treatment, whether as adjunct or alternative. Some of the powerful interlocking configurations Dr. Sander described will yield only—if at all—to interventions that have simultaneous impact on both parties.

The Philadelphia Psychoanalytic Society and Institute and The Jefferson Medical College announce the 21st ANNUAL MARGARET S. MAHLER SYMPOSIUM, to be held Saturday, May 19, 1990, at the Hershey Philadelphia Hotel. The title of the symposium will be "The Pathogenesis of Incest." For further information, contact: Ms. Gloria Schwartz, 1201 Chestnut St., Philadelphia, PA 19107.

The 11th ANNUAL CAPE COD INSTITUTE, a summer-long series of courses, symposia, film presentations, and master classes on topics of current interest to mental health professionals, will be held on Cape Cod, Massachusetts, June 25-August 31, 1990. Sessions are from 9:00 a.m. to 12:15 p.m., leaving afternoons free for leisure and study. The program is sponsored by the Department of Psychiatry of the Albert Einstein College of Medicine. For further information, contact: Dr. Gilbert Levin, Cape Cod Institute, Albert Einstein College of Medicine, 1303A Belfer Bldg., Bronx, N.Y. 10461. Phone: 212-430-2307.

The 4th INTERNATIONAL CONFERENCE of the Marcé Society, which was founded to promote the understanding, prevention, and treatment of mental illness related to childbearing, will be held September 4-7, 1990, at the University of York in England. For further information, contact: Conference Secretariat (Marcé), Bell Howe Conferences, 1 Willoughby St., Beeston, Nottingham NG9 2LT, England.